



E000103

THE HEALTH SERVICES IMPROVEMENT ACT OF 1970

AUGUST 11, 1970.—Ordered to be printed

MR. YARBOROUGH, from the Committee on Labor and Public Welfare,
submitted the following

REPORT

[To accompany S. 3355]

The Committee on Labor and Public Welfare, to which was referred the bills (S. 3355 and related bills) to amend titles III and IX of the Public Health Service Act so as to revise, extend, and improve the programs of research, investigation, education, training and demonstrations authorized thereunder, and for other purposes having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

SUMMARY

S. 3355 would extend for five years (fiscal year 1971 through fiscal year 1975) certain of the authorities under titles III and IX of the Public Health Service Act.

The bill would:

1. extend and improve the Regional Medical Programs authority (Title IX).
2. extend and improve the Comprehensive Health Planning and Services authority (section 314 of title III).
3. extend and improve the authority for the National Center for Health Services Research and Development (section 304 of title III).
4. improve the authority for the National Center for Health Statistics (section 305 of title III).
5. permit for the joint administration of projects involving more than one of the above mentioned authorities with the exception of section 305 (section 310a of title III).
6. require that the Secretary of HEW submit an annual report concerning the effectiveness of these programs (section 310b of title III).

7. create a National Council on Health Policy in the Executive Office of the President to conduct studies, research, and investigations to set goals for a national health policy for the United States.

8. enable the Secretary of HEW to authorize carriers participating in Federal health benefit programs for Federal employees to issue contracts for prepaid group practice health services to any person, whether or not such persons are Federal employees.

In order to carry out the purposes described above the Committee has authorized appropriations in the following amounts.

TABLE I.—AUTHORIZATION OF APPROPRIATIONS—S. 3355

[Amounts in thousands]

	1971	1972	1973	1974	1975	Total
Regional medical programs.....	150.0	200.0	250.0	250.0	250.0	1,100.0
Comprehensive planning and services:						
1. State planning (314a).....	15.0	17.0	20.0	30.0	35.0	117.0
2. Areawide planning (314b).....	20.0	30.0	40.0	50.0	60.0	200.0
3. Training of health planners (314c).....	8.0	9.0	10.0	11.0	12.0	50.0
4. Public health services (314d).....	130.0	145.0	165.0	180.0	200.0	820.0
5. Comprehensive health services development (314e).....	109.5	135.0	157.0	186.0	213.0	800.5
Health services research and development.....	84.0	85.0	94.0	110.0	130.0	503.0
National health council.....	.3	.7	1.0	1.0	1.0	4.0
Total.....	516.8	621.7	737.0	818.0	901.0	3,594.5

HEARINGS

Public hearings were held by the Health Subcommittee of the Committee on Labor and Public Welfare on February 17 and 18, 1970. Testimony in support of the bill and its overall purposes was received from a wide variety of eminent health and medical professionals, professional health and medical associations, and interested individuals. Additionally, a substantial number of statements were submitted and made a part of the hearing record.

BACKGROUND AND PROGRAM ACCOMPLISHMENTS

REGIONAL MEDICAL PROGRAMS

In 1964, a Presidential Commission on Heart Disease, Cancer and Stroke was initiated to recommend steps to reduce the incidence of these three diseases, which each year account for more than 70 percent of all deaths in the United States. The Commission's *Report* presented some 35 recommendations aimed at the development across the nation of regional complexes of medical facilities and resources. These were to function as coordinated systems to provide specialized services for the benefit of physicians and patients in the several geographic areas.

Legislative proposals submitted in early 1965 tended to follow the recommendations of the Commission, but these recommendations for a broad program of strong regional organization of health components were substantially modified. In the actual legislation enacted as the Heart Disease, Cancer and Stroke Amendments of 1965 (P.L. 89-239), the concepts of "regional medical complexes" and "coordinated arrangements" were replaced by "regional medical programs" and

"cooperative arrangements". The tone of the legislative package thus shifted to an emphasis on voluntary linkages and a less formalized regional organization pattern. A strong consideration in the decision was the pluralistic nature of our health-care system today, with a number of autonomous decision-making institutions useful to two or more Regions, increased the membership of the National Advisory Council from 12 to 16, and permitted participation of Federal hospitals in Regional Medical Programs.

BUDGET HISTORY—GRANTS

[Dollars in thousands]

	Fiscal year 1966	Fiscal year 1967	Fiscal year 1968	Fiscal year 1969	Fiscal year 1970
Authorization.....	\$50,000	\$90,000	\$200,000	\$65,000	\$120,000
Appropriation: grants.....	24,000	43,000	53,900	56,200	73,500
Add balance brought forward from previous year.....		21,934	25,900	36,165	20,000
Less amounts held in reserve by BOB.....		21,000	30,900	20,000	15,000
Amount available for obligation.....	24,000	43,934	48,900	72,365	78,500
Amount obligated—grants.....	2,066	27,052	43,635	72,365	78,500

During the hearings on the bill, the Committee was provided with evidence of substantial progress in implementing the concept and achieving the goals of the laws establishing and extending the Regional Medical Programs.

The concept of the law was to organize cooperatively public and private medical and health resources of people and facilities of what are, in effect, the various "health market areas" of the country. It was envisioned that, through such organizations, plans could be made and implemented that would directly result in the transfer of available new medical knowledge from the medical centers to the communities, thereby improving the quality of care and increasing the availability of that quality care, especially as it concerns heart disease, cancer, stroke and related diseases.

Of the 55 Regional Medical Programs established for planning purposes during the first two years of the program, 54 are now operational, their duration, as such, varying from over three years to only a few months.

The 55 programs cover the entire country, with Regional population coverages ranging from a few hundred thousand to as many as 20 million. In terms of area, 32 Programs cover entire states; 4 are combinations of entire states; 3 are combinations of states and segments of other states; and 16 are single metropolitan areas or larger segments of one or more states. As a result, the Programs vary in complexity, numbers of people and institutions involved, and types of activities they now have underway or planned consistent with their own needs and priorities.

Organizationally, 30 Programs have been established with their headquarters at universities or medical centers; 4 in state medical societies; 18 as newly chartered autonomous corporations; and 3 as other types of public or private non-profit agencies. This flexibility has permitted each Program to integrate itself into the various political, sociological and other resources of its own Region.

To make these Programs truly viable, virtually all elements of the health care system—medical schools, hospitals, academic and practicing physicians, dentists, members of all of the allied health professions, voluntary and public health organizations and agencies, and national, regional, state and local government agencies—which historically were reticent to join together in such cooperative arrangements, have had to become convinced of the need for implementation of the unique Regional Medical Programs concept.

Generally speaking, the following efforts of the Regional Medical Programs are being successfully realized:

They are developing a base for effective regional planning and decision making through broad representation and participation of health institutions, organizations and individuals on the planning committees and the Regional Advisory Group of each Region.

Through the professional and institutional linkages of regionalization, effective use of modern methods and techniques for diagnosis and treatment of heart disease, cancer and stroke, is increasingly achieved.

Improved distribution and maximum utilization of available health manpower resources of health manpower is being fostered through training of new types of personnel, the continuing education of personnel already in the health field, and demonstrations of patient care.

Facilities and resources for conducting demonstrations of patient care and diagnostic techniques are being increased and perfected, while the regionalization of the area's health care system is simultaneously promoted.

The following are a few examples of Regional Medical Program accomplishments, some of which are unique to the particular Region, and others characteristic of similar activities in many Regions:

In an isolated Appalachian area of Western North Carolina, known as the State of Franklin, a network of coronary care units of 13 electronically monitored beds in 8 different hospitals, has been established. This is a result of financial and technical assistance from the *North Carolina Regional Medical Program*. These eight small hospitals, all with less than 50 beds, are now linked together and to the cardiology department of the Bowman-Gray School of Medicine in Winston-Salem over 100 miles to the east by a telephone line for the transmission and analysis of electrocardiograms. Through the same local Regional Medical Program, many of the physicians practicing in this area and the nurses staffing these units have received training in the most up-to-date coronary care techniques.

In many Regions the Regional Medical Program staffs are actively working with representatives of the inner city in planning for improved health services. One type of such Regional Medical Program involvement is in the *California Region's* project in the Watts-Willowbrook section of Los Angeles. This is designed to work with all of the local, regional and state organizations and institutions involved to help establish the Drew Postgraduate Medical School of the Martin Luther King, Jr. General Hospital.

Some 3,000 miles away, the *New Jersey Regional Medical Program* has assigned full-time urban health coordinators to the Newark, Trenton and Hoboken Model Cities Offices to serve as health planners and identify and work with appropriate activities that may merit Regional Medical Program coordinated support.

The *Texas Regional Medical Program* is responsible for bringing high quality stroke rehabilitation to a small, rural town in East Texas. Prior to the implementation of this project, the East Texas Treatment Center in Kilgore, an isolated community with a modern rehabilitation facility, was under-utilized due to a lack of trained personnel and technical know-how required to provide a coordinated rehabilitation program for heart, cancer and stroke patients. As a result of the continuing working relationship developed by the Regional Medical Program between the Kilgore Treatment Center and the Southwestern Medical School, permanent staff and consultative personnel have been added; the skills and techniques of existing personnel have been upgraded; and a program organized whereby the local institution can carry out the same treatment and rehabilitation services found in the larger centers. It is hoped that the East Texas Treatment Center and two others being similarly aided will become links between the medical school and other rehabilitation centers in even more remote areas.

A program designed to meet the needs of local hospitals in the Spokane area for cardiopulmonary technician training is underway with support from the *Washington/Alaska Regional Medical Program* and cooperatively sponsored by the Spokane Community College, the County Medical Society, and the city's six hospitals. The community college is providing space and most of the faculty for the classroom phase; the physicians of the area, through their medical society, have helped in developing the curriculum and are assisting with the teaching; and the hospitals will eventually employ those individuals trained in the interest of the patients who are the residents of the area.

In Maine, one of the major projects supported by operational funds to the *Maine Regional Medical Program* is the development of the Upper Kennebec Valley Regional Health Agency. Located in Waterville, and originally organized as a voluntary service under a local board of trustees, this agency was activated by Regional Medical Program funds and now coordinated a series of several health-related planning and operational activities. With a combination of Regional Medical Program and local funds, the agency operated a Home Health Care Service which is effectively supplementing physicians' services to chronically ill patients to give the limited number of physicians in that area more time for seeing an increased number of patients who are critically ill. The agency is also operating a Regional Blood Bank which now serves 8 of the 10 hospitals in the Kennebec Valley. With additional Federal funds from the Department of Transportation, the agency's transportation and communications division provides rapid transfer of both patients and services for emergency care.

HEALTH SERVICES RESEARCH AND DEVELOPMENT

The National Center for Health Services Research and Development, which administers section 304 of the Public Health Service Act, was established on May 2, 1968, to serve as the focus of Federal efforts to improve health services nationally through research and development. At that time, virtually all existing programs within DHEW for the specific support of health services research and development were transferred to and became the initial base for the National Center.

Section 304 contains all the authority for research and demonstration with respect to hospitals and hospital operation which was previously contained in Section 624 of the Public Health Act.

Section 304, in addition, included the language of Section 314(e)(3) of the original "Partnership for Health" legislation, which authorized grants for projects to develop new methods or improve existing methods of providing health services, and related training.

BUDGET HISTORY—GRANTS

	1968	1969	1970
Funds authorized (sec. 304).....	20,000,000	40,000,000	60,000,000
Funds appropriated.....	30,670,000	41,030,000	44,975,000
Funds obligated.....	30,670,000	40,725,741	42,592,000

The accomplishments of the National Center for Health Services Research and Development can be divided into seven major categories: (1) Improvement of Health Services to the Disadvantaged, (2) Cost Containment R&D, (3) Health Services to Children, (4) Development of Auxiliary and Substitute Manpower, (5) Health Services Research Centers, (6) Technological Improvement in Health Services, and (7) Health Services Research Training.

(1) IMPROVEMENT OF HEALTH SERVICES TO THE DISADVANTAGED

A new method of delivering comprehensive health services that presents a simpler alternative to the creation of complex neighborhood health centers will be demonstrated and evaluated under a grant in Pittsburgh. A small team consisting of a physician, public health nurse, office nurse, social worker and community health aide will be the primary source of care services for 3,000 low income adults in a public housing project. A similar population in a contiguous housing project will serve as the control group.

Another project is evaluating the utilization of an OEO-financed neighborhood health center and of an RMP-financed multiphasic testing service by a largely black population living in a ghetto area. The population has access to both types of service. It will be possible to combine clinical data and information on acceptability of the services from people who use both services. Comparisons will then be made between this group and other individuals from the area who do not use either service, with respect to availability and receipt of health services, costs of delivering care actually received, costs of such services, and attitudes of individuals in the two groups about their use of and satisfaction with health services.

(2) COST CONTAINMENT R. & D.

The most prevalent practice in hospital billing is to identify the individual services performed for patients and itemize these in billing and in negotiating reimbursements. Individual pricing of hospital services is a complex practice which is costly to sustain and keep responsive to the requirements of payers.

An important project being carried out in Boston will ascertain the feasibility of using a general, or all-inclusive rate for reimbursing hospitals for patient care. Data will be collected from a number of representative hospitals in Massachusetts. This study will estimate the magnitude and types of potential cost savings associated with all-inclusive rates, as well as develop a patient classification scheme to be used with all-inclusive rates. Attempts will be made to determine acceptability of the inclusive rate to patients, providers of services, and payers. Changeover costs and obstacles to implementation (including statutory restrictions) will be examined. Based upon the successful outcome of the feasibility study, demonstrations will be initiated in several diverse communities across the country to further test the new methods.

(3) HEALTH SERVICES TO CHILDREN

The objective of a University of Colorado research program to increase health services to children is to develop a completely new type of child health professional (the "Pediatric Associate") and to evaluate his effectiveness in providing increased health services to children and in alleviating part of the present and future deficits of health manpower. The Pediatric Associate will be qualified to provide diagnostic, preventative and therapeutic services to more than 80 percent of children presently being given such services by pediatricians in their offices. The training of the Pediatric Associate will be completed in five years (from the time of graduation from high school until he is ready to go into practice) as compared to the eleven years now needed to fully train a pediatrician.

(4) DEVELOPMENT OF AUXILIARY AND SUBSTITUTE MANPOWER

General medical practice in rural American is suffering from severe shortages of physicians. There is a continuing migration of rural physicians to specialty practice and urban areas, in part, because of the inordinate pressures placed on these men. In addition, the average age of rural practitioners is much higher than their urban counterparts.

In an experimental program, (MEDEX), in rural Washington State, former independent duty military medical corpsmen have been selected by rural physicians with the help of the University of Washington medical school and the State Medical Association. These men have been retrained for their new role in civilian health care, and are currently working with their physicians on a one-year preceptorship. This project has far exceeded expectations. The physicians are delighted and relieved to have badly needed help. The patients were quick to recognize the skill and talent of these experienced young men, and the former corpsmen are pleased to find an outlet for the skills and training provided at public expense through the military. Many states have

requested that Medex programs be established in their rural areas, and the American Academy of General Practice is now planning with HEW to extend the Medex concept in areas where physicians desire this kind of augmentation.

(5) HEALTH SERVICES RESEARCH CENTERS

The Health Services Research Center grant program represents an effort to increase the amount of good research in this field and to assure that research findings are implemented in the actual delivery of care. Research Center grants provide support for long-term programs of multidisciplinary research, development, and demonstration with evaluation.

Each center is required to meet three conditions: (1) a major focus—either specific aspects of an operating health service program or the advancement of a particular technique of health services research; (2) direct access to a health services delivery system in which research findings may be carried through necessary developmental and demonstration stages; (3) agreement with providers of care to modify or create new forms of services in accord with the research results. Centers are encouraged but not required to include research training as part of their activities.

The activities of the seven active centers are summarized as follows:

University of North Carolina

This Center is evaluating alternative ways for providing optimum health services to all people of rural communities. Major research emphasis is on the problems of providing comprehensive programs of health care. This will involve experimental modifications of existing medical and dental practices at the community level.

Harvard Center for Community Health and Medical Care

The focus of the Harvard Center is the improvement of techniques for evaluating health care programs. Appropriate measures for assessing the extent to which health activities achieve their objectives are being developed. Using these measures, private and public programs will be evaluated to determine their impact upon those who use the services, as well as their impact upon the total community.

Kaiser Foundation Research Institute, Oakland, Calif.

This Center is developing a computerized medical data base and evaluating its impact upon the delivery of health services within a prepaid group practice medical and hospital care plan. It is assessing the contributions of this technological system to the quality and availability of care, while analyzing costs. Alternative uses of health services personnel will also be studied.

American Rehabilitation Foundation, Minneapolis, Minn.

This Center is concentrating on health planning and uses previous studies of the planning process in which the Foundation has been involved. A current project is examining national health services planning systems that have as their purpose improving the distribution of physicians and hospitals.

Northwestern University—American Hospital Association

This Center, combining the data resources and hospital management expertise of the American Hospital Association and the research

capability of Northwestern University, is examining methods of improving the effectiveness of health care institutions—primarily hospitals. The general approach is to conduct innovative demonstrations and evaluate them within the member hospitals of the Northwestern Medical Center. Current activities include a computer simulation of intensive care units and a study of hospital capital investments.

University of California—Los Angeles

The Primary objective of this Center is the development of criteria to evaluate health services and the use of these criteria in the evaluation and modification of health services delivery programs. Criteria will be developed to assess such factors as utilization, acceptance, satisfaction, and cost. Sites for implementing evaluation schemes include labor groups, government employees, and welfare recipients served by various systems of health care, such as a county hospital, a university hospital, and individual private practices.

Kaiser Foundation Hospitals, Portland, Oreg.

This Center, located within a group practice serving 115,000 people, investigates how individual, family, organizational, and other factors influence the utilization of medical care services. Experimental projects assess the cost and effectiveness of innovative methods of providing care, including their impact on utilization. Researchers from Portland State University, Reed College, the University of Victoria, and Oregon State are collaborating in this venture.

(6) TECHNOLOGICAL IMPROVEMENTS IN HEALTH SERVICES

The concept of equipping special areas such as intensive care units within a hospital to care for patients whose status is considered either critical or unstable is gradually becoming accepted medical procedure. Such intensive care units have been established for patients with recent myocardial infarctions, patients recuperating from major surgery of various kinds, and for patients in shock due to trauma, burn, or other causes. To be effective, such a unit must be not only a concentration of a specially trained medical and paramedical person but it must also provide some devices which aid these people in detecting the true physiologic state of the patient on a continuous basis and at the same time present information in a form which makes it available for optimal therapeutic decisions to be made. The system which is used at the Latter-Day Saints Hospital, Salt Lake City, for computer base monitoring of patients in an intensive care ward has been proven to meet the above objectives. In particular, the computer system permits automation of medical tasks in the area of surgical monitoring, intensive care, heart catheterization, electrocardiogram analysis, vital capacity measurement, coronary care, abnormal cardiac rhythm measurement and on-line statistical analysis.

This is one of several contracts the purpose of which is to: (1) demonstrate the transferability of the patient monitoring system developed at Salt Lake City to additional medical institutions; (2) provide an expanded capability for the continuous monitoring of critically ill patients at additional medical institutions in this country; (3) create a facility in which medical and paramedical personnel can be trained in advanced techniques for the monitoring of critically ill patients;

(4) provide additional sites wherein advanced patient monitoring techniques can be demonstrated and in turn emulated; (5) provide a minimum basis of monitoring capability upon which additional improvements can be made as specific new techniques are developed for patient surveillance; (6) provide a sufficiently large and versatile computing facility such that it will be possible to extend the capabilities of automation to other areas of the administration of medical care in hospitals.

(7) HEALTH SERVICES RESEARCH TRAINING

The Training Program in Medical Care Organization being supported at the University of Michigan is concerned with the study of the organizational arrangements through which medical care services are made available to the population. In the program of study leading to the Ph. D. degree in medical care organization, these arrangements are studied from three perspectives: as administrative systems, as economic systems and as sociological systems.

The study of the administrative aspects of medical care organization is concerned with the types of services provided under such arrangements as private medical practice, hospitals, group medical practice, public health agencies, public welfare medical care, voluntary health agencies; the distribution of health personnel; the utilization of services by different categories of the population; and administrative solutions to problems in the rational coordination of services to meet new or unfilled needs.

The economic aspects of medical care focus on pricing mechanisms in medical care, on factors affecting the cost of care, the determinants of supply and demand for services and the analysis of various payment arrangements such as private payment, voluntary health insurance and tax-based arrangements.

The sociological aspects of health arrangements are studied by analyzing the relationship between the cultural and social elements of health organizations and the behavior of both patients and practitioners.

Each student in the Program is required to concentrate in one of the theoretical fields relevant to the study of medical care organization and financing such as sociology, economics or public administration.

COMPREHENSIVE HEALTH PLANNING AND SERVICES

With the passage of Social Security Act of 1935, the Federal government undertook for the first time on a continuing basis a share of responsibility with the States in public health. For the next thirty years financial assistance was provided to the States through a series of formula grants. One was for general health support and eight others were so-called categorical grants relating to particular diseases or to some other defined segment of public health. The tendency during these years was to initiate a new Federal grant program to stimulate or assist State and localities in coping with health needs on a problem-by-problem basis.

With the enactment in 1966 of Public Law 89-749 and in 1967 of Public Law 90-174, the Partnership for Health legislation, the concept of joint Federal-State responsibility for health, came of age. By providing for the first time, comprehensive planning assistance and by consolidating nine categorical programs into a single bloc grant

which State Public Health and Mental Health authorities could use in accordance with their individual priorities for establishing and maintaining adequate public health and mental health services, the Congress encouraged State to initiate and follow through on efforts to peg health needs, set health goals, and start realistic achievement activities.

The project grants for health services development also originated in categorical grants. Section 314(e) of Public Law 89-749 replaced a project grant authorization (in former section 318 of the Public Health Service Act) for new or improved out-of-hospital community health services as well as subsuming authorizations in annual appropriation acts for certain disease control and other continuing health support activities such as cancer control, mental retardation, neuroradiological health problems. The new 314(e) permitted project grants for program support, development, and demonstration purposes not only for the former categories but also for other areas such as dental health, urban health, narcotics and drug addiction, rural health services, family planning, and alcoholism.

FUNDS AUTHORIZED, APPROPRIATED, AND OBLIGATED FOR SEC. 314 PURPOSES

(In thousands of dollars)

	Authorized	Appropriated	Obligated
314(a):			
1967	2,500	2,500	
1968	7,000	5,000	4,800
1969	10,000	17,375	7,356
1970	15,000	8,175	
314(b):			
1967	5,000		
1968	7,500	7,500	3,031
1969	10,000	7,000	6,983
1970	15,000	7,700	
314(c):			
1967	1,500	1,500	
1968	2,500	2,500	1,738
1969	5,000	4,125	3,656
1970	7,500	4,125	
314(d):			
1967		52,250	
1968	70,000	60,250	59,648
1969	90,000	56,032	65,737
1970	100,000	100,000	
314(e):			
1967		58,000	
1968	90,000	62,500	56,421
1969	95,000	79,000	77,077
1970	80,000	80,000	

* Budget authority reduced by \$250,000—transferred to 314(e) for rubella immunization supplemental.

(1) COMPREHENSIVE HEALTH PLANNING (314 (a) AND (b))

The first State Comprehensive Health Planning grant (to Illinois) was approved July 1967 and by July 1968 all 56 eligible jurisdictions had been approved for formula grant assistance although one State (Nevada) has dropped out of the program temporarily.

State CHP agencies are in varying states of development but in general they have moved through the organizational stages into substantive planning. CHP agencies are demonstrating their effectiveness in attacking inadequate health care and eliminating duplication of resources including facilities and manpower.

For example, some State planning agencies have been instrumental in improving licensing requirements. Another was instrumental in

transforming categorical care programs for mentally ill, mentally retarded, and inebriate patients into multi-purpose regional centers. One recommended consolidation of State agency functions relating to health facilities to eliminate overlap and unnecessary duplication. Another recommended discontinuance of special hospitals for tuberculosis patients, which may have an impact on the utilization of outmoded tuberculosis hospitals or the merging of some hospitals. Another prepared a universal health insurance proposal for the Governor who, in turn, submitted it to the State Legislature. Another assessed areas of need for ambulance services. One conducted a background study leading to the State's adoption of the medicaid program.

Others have helped improve professional training resources. And still others have moved toward filling gaps in environmental health protection. As a service to the official clearing house (of which it is a part) one was designated the official reviewing agency for all health aspects of construction and planning grants, in accordance with BOB Circular A-95.

The first appropriation for *areawide* comprehensive health planning was made by the Congress in November, 1967. A total of 113 areawide comprehensive health planning agencies are now receiving Federal support. At the end of the third funding period, approximately April 1, 1970, there were 13 areas receiving grants to conduct areawide comprehensive health planning; that is, they had completed their organizational period. The population in these areas is approximately 16 million, or 8 percent of the national population. At the end of fiscal 1970, there will be 36 areas receiving such planning grants, with a total population slightly over 31 million, or about 15 percent of the national population. By the end of fiscal 1971, there will be over 95 agencies conducting areawide comprehensive health planning, covering areas with over half the national population.

It should be noted that many areawide comprehensive health planning agencies still supported by grants for organizational purposes conduct some planning activities in response to community demand or opportunity.

Although only a few areawide agencies are as yet conducting full planning programs, many have influenced area actions. Some of these influences are expressed through the areawide planning agencies' developing health planning components of Model Cities plans. Another is expressed by the agency's arranging language training for health professionals serving Spanish-speaking poor. In some instances, areawide CHP agencies have recommended a moratorium on hospital building or expansion until needs can be clearly determined. There have even been instances in which areawide CHP agencies have brought about mergers of formerly separate hospitals. In most States and communities there is an interest in the program and growing belief in its potential to improve the effectiveness and economy of the organization and delivery of health services.

(2) PROJECT GRANTS FOR TRAINING, STUDIES, AND DEMONSTRATIONS (314(c))

The first appropriation for grants to public and non-profit organizations for training, studies, and demonstrations to improve comprehensive health planning was not available until late in Fiscal Year 1967. Under this program a total of 39 grants to public and non-profit

organizations currently are providing long-term graduate training to over 200 students, continuing education for over 500 professional persons, and consumer education reaching over 700 persons. Two more graduate programs are in a developing stage.

The long-term academic programs are geared to equipping students who are new to the field with the principles and concepts used by State and areawide comprehensive health planning agencies so they will be able to operate effectively in this field.

Continuing education programs are aimed at "retreading" individuals already involved with health planning to increase their knowledge and skills in the concepts and techniques of comprehensive health planning.

Consumer training has been directed principally toward orienting the nonprofessional person in order that he may participate more effectively in the comprehensive health planning process.

Eight studies and demonstrations are also being supported to develop new tools and techniques for use by State and areawide comprehensive health planning agencies.

(3) FORMULA GRANTS FOR COMPREHENSIVE PUBLIC HEALTH SERVICES (314(d))

For over thirty years the Federal government provided financial assistance in health matters to the States through a series of formula grants. One was a general health grant and eight others were so-called categorical grants relating to a particular disease or to some other rather limited segment of public health. With the enactment, in 1966, of PL 89-749 the nine categorical formula grants were consolidated into a single block formula grant in order to permit the States greater flexibility in using the Federal assistance to meet their own health needs, goals and priorities.

State and Federal funds, as reported in the State Plans, support such programs and services as chronic disease control, communicable disease control (including tuberculosis and venereal disease), dental health, environmental health (including food and drug protection, occupational or industrial health, radiological health, and sanitary engineering), laboratories, licensure and improvement of standards, heart disease, home health, and mental health (including alcoholism and various community health services). Encouraging changes in regard to the use of formula grants are being noted. While many States are continuing to support categorical grant programs at the same or increased levels, some States are also becoming increasingly concerned with systems and health service delivery methods. They are directing programs and services toward such "high risk groups" as the poor instead of following stereotyped disease category lines.

Other significant differences are emerging in 1970 plans. States are addressing themselves to individual priorities. Vermont and New York, for example, place major emphasis on the expansion of home health services. West Virginia gives high priorities to systematic State-wide expansion of services related to family planning, environmental health, and dental health. New Mexico reflects some redirection toward suicide prevention and drug abuse, as well as a broad effort to develop, promote, and integrate mental health services.

Increasingly States are distributing more funds to local health jurisdictions. It is evident from FY 1970 State Plans that almost all States have developed methods and techniques for channeling funds to local communities. A good many States have developed formula grant mechanisms to facilitate the distribution of both Federal and State funds to these communities. In some cases States distribute funds on a project by project basis. There are a few instances in which both techniques are employed. States are also becoming more involved in the provision of technical assistance and consultation to the urban areas within their boundaries.

(4) PROJECT GRANTS FOR HEALTH SERVICES DEVELOPMENT (314(e))

The Project Grants for Health Services development also evolved from categorical grant origin. Section 314(e) of Public Law 89-749 replaced project grant authorizations of Section 318 of the PHS Act (for new or improved out-of-hospital community health services) as well as authorizations in annual appropriation acts for certain disease control and other continuing health support activities (e.g. cancer, mental retardation, neurological and sensory diseases, venereal disease, tuberculosis, dental health, urban health programs).

Many of the categorical 314(e) project grants are continuing, but the trend is toward bringing them into a larger framework of the organization and delivery of health services.

Non-categorical projects support comprehensive health service programs or components thereof. A variety of different models are being encouraged with respect to orientation, operation, and funding of comprehensive health services programs. However, focus is on programs which assure accessible ambulatory care, which incorporate sound preventive health measures, which are predicated on total family care and which are designed to insure continuity of care. It is under this authority that HEW is absorbing responsibility for the "mature" neighborhood health centers transferred from the Office of Economic Opportunity.

As of May 31, 1970, 318 categorical service projects, 50 comprehensive programs including 24 comprehensive health centers (and 26 developmental and component projects) were being supported.

HEALTH SURVEYS AND STATISTICS

The National Center for Health Statistics was organized in August, 1960, upon the recommendation of the Surgeon General's *Study Group on Mission and Organization of the Public Health Service*. The legislative authority for the Center's operations is provided by Title III, Part A, Sections 301, 305; Part B, Sections 311(b), 312, 313, and 315.

Although the Center was formed in 1960, some of its activities developed much earlier. Deaths were enumerated for the first time in the Census of 1850. From 1850 to 1901 there were a variety of laws governing the periodic reporting of vital statistics to the U.S. Census Office. The Permanent Census Office Act of 1902 provided, in part, that:

There shall be a collection of the statistics of the births and deaths in registration areas for the year 1902 and annually thereafter, the data for which shall be obtained only from and restricted to such registration records of such States

and municipalities as in the discretion of the Director possess records affording satisfactory data in necessary detail. * * *

The Public Health Service Act of 1902 amended and reenacted the act establishing the Public Health Service. Section 8 of that Act provided:

To secure uniformity in the registration of mortality, morbidity, and vital statistics, it shall be the duty of the Surgeon General * * * to prepare and distribute suitable and necessary forms for the collection and compilation of such statistics and such statistics * * * shall be compiled and published by the Public Health and Marine Hospital Service. * * *

This section has remained in each compilation and revision of the Public Health Service Act since 1902. The Vital Statistics Division of the Bureau of the Census was transferred to the Federal Security Administration by Reorganization Plan No. 2 of 1946 and renamed the National Office of Vital Statistics.

In 1955 the Department of Health, Education, and Welfare proposed a plan under which the Surgeon General of the Public Health Service would be authorized to conduct a continuing survey of illness and disability in the Nation. A recommendation that Congress enact such legislation was included in the President's legislative program on health matters. Bills incorporating the proposals were introduced in both the Senate and House of Representatives in February 1956, and after hearing testimony on the needs of improved health statistics, Congress passed the National Health Survey Act (Public Law 652, 84th Congress). The bill was signed by the President on July 3, 1956, and later in the same month funds were appropriated for the first fiscal year of operation of the National Health Survey.

A recommendation of the Study Group on Mission and Organization of the Public Health Service in 1960 resulted in the relocation of several statistical functions of the Service within the newly created National Center for Health Statistics. This new organization was initially composed of the National Office of Vital Statistics and the National Health Survey thereby bringing together the major components of the Public Health Service competence in the measurement of health status of the Nation and the identification of significant associations between characteristics of the population and health related problems.

NATIONAL CENTER FOR HEALTH STATISTICS

[Dollars in thousands]

	Funds authorized	Funds appropriated	Funds obligated
1962	4,642	4,642	4,486
1963	5,149	5,150	5,140
1964	5,949	5,949	5,987
1965	6,304	6,304	6,277
1966	7,230	7,230	6,945
1967	9,312	9,312	8,942
1968	8,317	8,317	7,871
1969	8,225	8,230	8,126
1970	19,355	8,841	129,975

¹ Includes \$524,000 increase for pay costs.

² Estimated.

Note: Reimbursements are excluded from this table.

Since the National Center for Health Statistics was organized in 1960 it has provided health data to serve needs of all segments and levels of the health professions, both public and private. The principal form of output has been some 300 publications, although approximately 80 requests are received each day for unpublished information or tabulations. These data are used in connection with proposed federal or state legislation, hearings of committees and commissions, planning of federal and state health programs, and assessment of program progress; they are used as baseline data for research programs in government and universities, and in teaching in the health sciences; they are employed in the production of intercensal population estimates and projections, in the production of national and state life tables, and for other demographic applications related to the rate of growth and characteristics of the population; and they are used widely by private industries engaged in insurance, health care services, and production of appliances and medications.

The National Center for Health Statistics develops and operates continuing statistical systems for the collection, analysis and dissemination of various classes of health data.

The vital statistics system has annually produced the national and state volumes of data on births, deaths, marriages, and divorces. In addition, this program has produced the annual life tables for the United States and 35 analytical reports on subjects such as infant mortality, suicides, homicides, illegitimacy, fertility, and pre-natal care. Each year about 30,000 people are informed as to how to receive birth or death information on their kin, and 4,000 handbooks on vital registration are distributed to physicians and hospitals.

The Health Interview Survey has produced 60 analytical reports with a distribution of 6,000 to 10,000 copies each. The subjects include illnesses, injuries, chronic disability, work and school loss, and use of medical and dental services. Data on hospitalization, health insurance coverage, and health expenditures were used extensively in connection with Medicare legislation and also in committee hearings on the Economics of Aging.

The Health Examination Survey has distributed 40 reports and large volumes of specialized clinical data based upon examinations of samples of the population. This program uniquely produces national population norms for a wide range of physical and physiological findings related to diseases and sensory disorders. It also detects the level of diseases and abnormalities which had not been previously diagnosed, thus leading to an assessment of the needs for health care. Such data are in demand for the planning of health care programs and of resources to meet health needs. The examination program is now producing information on growth, development, and psychological attributes of children, and is testing methods for conducting a continuous assessment of the nutritional status of the population, particularly among the poor.

The Health Resources Surveys produce statistics on the numbers and characteristics of health care facilities, their employees, and their patients, including a continuing survey of the utilization of in-hospital services. It also furnishes information on the amount and distribution of health and medical manpower. During the past six months this program has organized and is operating a national system for uniform reporting of services provided in family planning clinics.

The project is still incomplete, but the objective is to measure progress in reaching the goal of providing such services to all those in need.

In addition to directing the statistical systems noted above, the National Center for Health Statistics carries on a program of research in statistical methodology and survey techniques. Thirty-six methodological reports have been produced. During the past ten years the staff has responded to about 200 requests for technical assistance on research design, survey methods, or establishment of data systems.

An Applied Statistics Training Institute offers one- to two-week courses in methodology, computer applications, data uses in health program planning, and other practical subjects. In 1969 there were 270 students from 46 state offices, two territories, and 7 Federal agencies.

The Center has developed an international reputation for competence in health statistics. About 1800 individuals and organizations in other countries receive the publications. The Center staff represent the United States in negotiations on international classifications of disease, and serve as WHO consultants and committee members. The staff provides project direction for 16 health research programs in foreign countries under the provisions of Public Law 480. With financial support from the Agency for International Development, the National Center for Health Statistics each year provides training in health and demographic statistics for 10 to 16 students from developing countries.

COMMITTEE ACTIONS AND COMMITTEE VIEWS

OVERVIEW

The Committee in reporting favorably on S. 3355 gave careful consideration and attention to the Administration's proposals for the extension and transformation of the Regional Medical Programs, Comprehensive Health Planning, and Health Services Research and Development. Essentially, the Administration's proposal (S. 3443) would have prematurely blurred the related, yet different, purposes of these developing programs. It would have merged the Regional Medical Programs with the other two, both of which are in far earlier stages of development. It would have diluted the effectiveness of the RMP National Advisory Council, which has been an essential instrument for national policy development and quality control.

While it is essential that the relationships among these three programs be clarified (not blurred) such that they can productively affect one another, that clarification should not be legislatively mandated at this stage in their development. The substantive complexities of bringing greater rationality to this country's health care industry demands that we eschew superficially appealing "simple solutions".

The Committee's Bill, S. 3355, would extend these programs for an additional five years, thereby giving them an opportunity to gain greater maturity. Importantly, the bill contains provisions (discussed below) which would substantively enhance the capacity and the capability of those who administer and implement these programs—both here in Washington and across the country. The Committee intends that this additional time for development and increased administrative and program capacity will bring into sharp focus the

specific ways in which these efforts can be better related, including any necessary legislative modifications.

TITLE I

Title I of the bill would extend and improve the authority for the Regional Medical Programs. Specifically, it would:

1. Explicitly authorize contract authority. As part of a generally broadened scope for Regional Medical Programs, the committee feels that it is appropriate that explicit contract as well as grant authority be made available to the Regional Medical Programs. This will be especially useful in such areas as the training of specific types of manpower which meet the national needs of Regional Medical Programs, including continuing education specialists and medical education evaluators. Contract authority would provide an alternative to training that is specifically carried on by or through individual Regional Medical Programs, and allow for other short-term developmental work in such areas as medical records systems.

2. Broaden the categorical purview of the RMP to include kidney disease and other major diseases and conditions.

In broadening the disease focus of Regional Medical Programs, the committee feels that the program should move—as they are already showing a tendency to do—beyond the categorical limitations of heart disease, cancer and stroke. By broadening the scope of the program, the individual Regional Medical Programs will have a wider range of options to deal with those diseases and conditions most urgent in their area and for which they often have ready capability. A broadened program authority would allow the mechanism of regional cooperative arrangements to be used to more comprehensive advantage.

The specific inclusion of kidney disease in Regional Medical Programs reflects growing concern over the national status of this major chronic disease. Nearly 8 million persons in the United States are afflicted with kidney disease, of which about 60,000 progress to a terminal disease condition and death each year if life-sustaining treatment is not available. Diseases of the urinary tract rank fourth among causes of death from chronic disease. Kidney disease also tends to strike in the middle, most productive years of life, compared to other chronic diseases.

The new focus on kidney disease proposes to accelerate improvement in the state of the art within the context of the existing regional planning and operations of Regional Medical Programs. The broadened program authority will promote testing and evaluating methods for prevention and control at the community level, and support the organization of kidney disease programs on an interregional basis across the Nation. These grants will be especially useful in terms of stepping-up the end-stage kidney disease program as it moves into the realm of kidney transplantation.

In order to provide a specific focus to kidney disease, the proposed legislation specifies that a maximum of \$15 million of the amount appropriated in fiscal year 1971 be available for kidney disease activities. It also specifies that the National Advisory Council on Regional Medical Programs shall include membership outstanding in the study or care of kidney disease.

Alcohol abuse, alcoholism, drug addiction and drug abuse constitute one of the most serious health concerns in the Nation today.

For example, there are over 9 million alcoholics in the United States. One of every three arrests in America is for simple public intoxication. It has been estimated that as many as 50 million people may be affected by excessive use of alcohol. The human waste caused by alcohol abuse is tragic and unacceptable; the economic waste attributable to it has been estimated at \$7 billion a year. An adequate response to problems of this magnitude requires a massive Federal approach. Alcoholism and drug dependence are problems of our entire society. It will take a major effort to make significant progress in controlling them. The Regional Medical Program mechanism, with its broadened authority, can and should make a significant contribution to the alleviation of these diseases. It establishes a framework within which, for the first time, a public-private partnership of health professionals and interested laymen can effectively utilize health and rehabilitation resources to bring these problems under control. The Committee expects that each Regional Medical Program will begin to grapple with these major diseases in a way which is commensurate with the enormity of the toll they exact from our society.

3. Authorize prevention and rehabilitation (including home health care) activities.

The bill makes explicit that prevention and rehabilitation, including home health care, as well as diagnosis and treatment of heart disease, cancer, stroke, kidney disease and other major diseases and conditions, are clearly within the scope of the program. Although the legislative history makes it clear that prevention and rehabilitation are included within the original scope of Regional Medical Programs, it seems appropriate to include these expressly in the statutory language, particularly in view of the increasingly important role of prevention, not only with respect to the categorical diseases, but health in general, and the need for a stronger role for home health care.

4. Enable the RMPs to emphasize primary care activities as well as additional regionalization efforts.

The Committee recognizes the role of Regional Medical Programs in fostering linkages among health care institutions and providers so as to strengthen and improve primary care, and emphasizes the need for improved relationships between specialized and primary care. It also places increased emphasis on the need for increasing the capacity as well as the quality of the Nation's health manpower and facilities, and on improving health services for persons residing in areas with limited health services.

5. Authorize funding levels which are modest when compared with the enormity of a national effort of this kind. The bill authorizes: \$150,000,000 for fiscal year 1971; \$200,000,000 for fiscal year 1972; \$250,000,000 for fiscal year 1973; \$250,000,000 for fiscal year 1974; \$250,000,000 for fiscal year 1975.

6. Enable the RMPs to involve themselves in activities dealing with the organization and delivery of health care.

Federal health programs have emphasized heavily the financing of health services, but have not paid sufficient attention to the way in which those services are organized and delivered. The need to act to create improved systems of health care at the local level is essential, since the present patchwork system is clearly inefficient, is pushing costs higher, does not provide care for all who need it, and is not responding fast enough to meet the urgent need for change.

Regional Medical Programs, among others, are already engaged in important related aspects of planning and development, in this substantive area, growing out of its categorical efforts. It is essential that the gains made to date by the Regional Medical Programs in the area of organization and delivery of health care should be conserved, supported, and enhanced, both because what they have done in many cases is to lay the necessary groundwork for health care system building and because they have captured the imagination, enthusiasm and cooperation of a widely varying group of providers and consumers across the country. No other federally supported health program has, as yet, accomplished that, and the Committee intends that that accomplishment not be diluted or distorted.

The Committee has thus provided the opportunity, at the option of the applicant, for Regional Medical Programs to engage in developing and demonstrating systems for organizing and delivering medical care. Recognizing that there are no simple solutions to the problem of how to bring about improved health care systems, it is apparent that Regional Medical Programs have an important contribution to make in examining the wide variety of potential approaches.

7. Authorize new construction. The bill provides for new construction of facilities for demonstrations, research and training when necessary to carry out Regional Medical Programs. The need for construction funds is generally limited to specific types of facilities. These include continuing education and training space, particularly in community hospitals, and involve in some cases the upgrading and expansion of laboratory facilities to be used in training paramedical personnel.

8. Strengthen the developing relationships with the Comprehensive Health Planning Program.

The relationships between Regional Medical Programs and Comprehensive Health Planning agencies have been quite varied across the Nation. In some cases, there has been close cooperation, involving overlapping membership on advisory councils, joint planning and data collection efforts and common definition of subregional areas. In others, there has been little or no contact. Unfortunately, in yet others the relationship has been counter-productive.

The committee encourages the development of a close working relationship between these programs, especially at the regional and local levels. The programs need to complement and support one another as they work with the health institutions and consumers in their area. To further promote such cooperation and coordination, the bill provides for representation on the Regional Advisory Groups of official health and planning agencies. At the same time it provides within the Comprehensive Health Planning authority for representation of Regional Medical Programs on the State Health Planning Councils, and on the Areawide Health Planning Councils which are to be established.

The bill also provides that before a Regional Advisory Group may recommend approval of an operational grant, the opportunity must be provided for consideration of the application by the appropriate Areawide 314(b) Comprehensive Health Planning Agency. This is designed to ensure greater coordination of health planning and programming efforts at the local level and adherence to community established priorities.

9. Broaden the scope of both the Regional Advisory Groups and the National Advisory Council on RMPs.

In addition to providing representation on Regional Advisory Groups to official health and health planning agencies, the bill requires that where there are hospitals or other medical facilities of the Veterans' Administration within the geographic area of a Regional Medical Program, a representative of these facilities be included on that program's Regional Advisory Group, as an ex officio member.

V.A. representation in Regional Medical Programs would insure that their treatment procedures would be up to date with modern developments and techniques. Likewise new techniques developed in the V.A. system could be immediately brought to the attention of the community. The RMP-sponsored continuing education programs in the treatment and prevention of diseases could have a highly beneficial impact on all hospitals, particularly those V.A. hospitals in remote areas. Many of the university-affiliated V.A. hospitals could in turn make outstanding contributions to development of these educational programs. In the critical disease areas of the regional medical programs, treatment facilities and procedures are highly specialized and extremely costly and normally are not operated 100% of the time. A great opportunity exists for sharing or joint planning in the establishment of such facilities.

The bill also seeks to increase the community-based input into Regional Medical Programs decision-making, by calling for public members on the Regional Advisory Group familiar with the need for and financing of the services provided under the program, and for adequate community orientation.

Requirements with respect to the National Advisory Council on Regional Medical Programs, which under title IX of the Public Health Service Act must make recommendations to the Secretary on program policy and grant application, would be modified. The bill requires that one member of the Council be outstanding in the study or care of kidney disease, to match a similar requirement for heart disease, cancer and stroke; that it include leaders in the field of health care administration as well as in the fundamental and medical sciences; and that at least three of its sixteen members shall be members of the public.

Such representation should provide better communication with those who are advising on Regional Medical Programs, and contribute effectively to an improved use of the Nation's resources.

10. Broaden the scope of the multiprogram services which RMPs can provide.

Regional Medical Program authority to make contracts with public or private nonprofit agencies, institutions or organizations for the conduct of cooperative clinical field trials and demonstrations relating to the development of improved methods for control of heart disease, cancer, stroke, kidney disease, and other major diseases and conditions, is general (as authorized under Section 301 of the Public Health Service Act) rather than specific. Because of opportunities for support of these and training activities meeting national demands for certain types of health manpower, the Committee would prefer to have grant and contract authority specifically included within title IX of the Public Health Service Act.

This would also continue authorization for those interregional support activities of use to two or more Regional Medical Programs. This might include interregional support for such activities as communications networks, data collection systems, and training and evaluation efforts.

TITLE II

Title II of the bill would extend and improve the authority for the National Center for Health Services Research and Development, the National Center for Health Statistics, and the Comprehensive Health Planning and Services Program. Title II would also permit, in appropriate and limited circumstances, the joint administration of the programs authorized in S. 3355, as well as require the Secretary of HEW to report annually to the Congress on the effectiveness of those programs.

Specifically, it would:

1. Require the Secretary of HEW to design and analyze alternative universal health care plans for the United States.

The purpose of new subsection (b) of Section 304 of the Public Health Service Act is to provide the Congress with information on alternative means of improving health care in the United States. At present, the country has a health care industry which costs the economy more than \$60 billion a year, but which yet is not capable of delivering adequate health to every American. The Committee expects the systems analysis authorized in this new subsection to produce comprehensive national health care plans which could serve as viable alternatives to the present inefficient and ineffective non-system of health care.

The Secretary, under the provisions of new subsection (b) (1) (A) would be expected to develop criteria as to the level of health services needed to provide adequate health care and then develop alternative national health care plans to meet those criteria.

Each alternative plan which the Secretary develops would be keyed to a different financing mechanism for the payment of health care services.

Financing mechanisms which could serve as the basis of alternative plans should include the following:

- a payroll deduction and general revenue plan, such as outlined in Senator Javits' bill, S. 3711;

- a tax credit plan, such as outlined in Senator Fannin's bill, S. 2705;

- a Federal payment of private health insurance premiums plan such as suggested by the Aetna Insurance Company;

- and a plan for a regional mix of financing proposals to utilize a different financing approach in various regions of the country.

Each plan should describe the changes in methods of health delivery, in health administration, and increases in health manpower and numbers of health facilities, which would be required if a particular financing plan was to be implemented. Upon completion of the alternative national health care plans, the Secretary would submit them to the Congress in the terms described in subsection (b) (1) (B). The Committee expects the legislative and administrative changes required by each plan to be prepared as if each plan was to be implemented.

The Secretary is authorized to utilize whatever personnel is necessary to implement his system analysis. It is expected that the Secretary would designate a study task force consisting of Federal personnel from concerned agencies, outside medical personnel, lawyers and economists.

The National Center for Health Services Research and Development would be expected to serve as the lead agency for the task force.

New subsection (b) (2) (A) requires the Secretary to report to Congress as to cost and to the degree of health coverage which would be afforded to the population if various national health insurance proposals introduced in the 91st Congress were enacted. It is expected that the Secretary's evaluation of these proposals will be less comprehensive than the systems study authorized and will be in the form of an Executive Branch report on legislative proposals. The Committee believes that it is necessary to know the Executive Branch's evaluation of existing universal health care proposals at an earlier date than the date for the completion of the systems study in order that the Congress will not be excessively delayed in its deliberations on similar health measures in the coming session.

2. Authorize funds necessary to carry out the purposes of section 304: \$84,000,000 for fiscal year 1971; \$85,000,000 for fiscal year 1972; \$94,000,000 for fiscal year 1973; \$110,000,000 for fiscal year 1974; \$130,000,000 for fiscal year 1975.

3. Authorize projects dealing with research, experiments, and demonstrations into the combination or coordination of health care delivery systems.

The Administration recommended that the Congress adopt a proposal reenacting the programs extended in the committee bill in a single title of the Public Health Service Act, putting them under the jurisdiction of a single advisory council, and otherwise creating at least an appearance that the separate programs were to be considered legally merged or administratively combined. The Committee rejects that notion. The Committee feels strongly that each of these programs has a particular contribution to make and that any combination of them which might result in the submergence of the particular advantages of one in favor of those of another is unwise at a time when these relatively new enterprises are just beginning to realize some of the expectations which led to their original establishment as distinct entities.

Yet short of the subsuming of one program by another, the committee is convinced of the wisdom of further studies and demonstrations as to how these activities may be more effectively brought together and coordinated, especially at the local levels where health manpower and other specialized health resources are scarce and the premium on their optimum utilization correspondingly high. The Committee therefore has provided a specific authorization under section 304 of the bill, as amended, for research, experiments and demonstrations dealing with the combination or coordination of public, private, or mixed health services delivery methods or systems at various jurisdictional and governmental levels.

The committee believes these and other types of projects can serve not only to improve health services delivery at the non-Federal level, but also to give the Administration and the Congress a better understanding of how these inherently related grant programs may be made more mutually productive.

4. Broaden the authority under which health studies and surveys are conducted under section 305 of the Public Health Service Act.

The most immediate effect of the section of the legislation dealing with the research and development leading toward a cooperative federal-state-local health statistics system would be the construction of a model for a nationwide system linking the efforts of localities, states, and the federal government in providing comprehensive statistics on health, health services, health resources, and other related health matters.

Legislation and supporting policies for regional medical programs, comprehensive health planning agencies, vocational rehabilitation efforts, and numerous other health programs make clear that the plans for these activities shall be based upon an objective assessment of health needs in the states and communities. At the present time much of this statistical base is missing. Authorities granted under the National Health Survey Act of 1956, and older legislation calling for national vital statistics, have within recent years led to the establishment of prototype models of systems for producing health statistics of a number of useful types. However, these data suffer from their lack of the fine-grained detail, particularly lack of geographic detail, that is needed for establishment of priorities and allocation of resources. Not only are the data insufficient for identifying the health program needs peculiar to a state or local jurisdiction, but they do not permit the sort of pinpointed evaluation which is required for comparing changes in health status between areas in which health services programs have been developed and those being watched as controls. For effective evaluation one needs to be able to make such comparisons in order to draw conclusions about the results that can be attributed to new program activities.

A fully-developed system which would provide states and localities with uniform statistics on health and health services would not only permit these jurisdictions to analyze the results of their programs in the necessary detail, but it would provide a source of statistical information for the use of the federal government in marking progress toward national goals. The committee intends to bring that system into being under the proposed broadened authority.

5. Extend and improve the five-part Comprehensive Health Planning and Services Program under section 314 of the Public Health Service Act.

State Health Planning—section 314(a).—The bill would authorize \$15,000,000 for fiscal year 1971, \$17,000,000 for fiscal year 1972, \$20,000,000 for fiscal year 1973, \$30,000,000 for fiscal year 1974, and \$35,000,000 for fiscal year 1975 to enable the States to continue, expand, and improve their statewide health planning programs.

The Committee intends that the term "health care facility" under section 314(a) would not include facilities such as those provided by the Christian Science Church, relying solely on spiritual means through prayer for healing.

Areawide Health Planning—section 314(b).—The bill would authorize \$20,000,000 for fiscal year 1971, \$30,000,000 for fiscal year 1972, \$40,000,000 for fiscal year 1973, \$50,000,000 for fiscal year 1974, and \$60,000,000 for fiscal year 1975 in order to enable additional areawide health planning programs to begin planning.

Because of extreme geographic distances and isolation, or because the population base is too small to justify support for areawide plan-

ing grants, it is not feasible for some areas, particularly rural areas, to be included at this time in existing areawide comprehensive health planning. Such areas cannot support, attract, nor use full-time trained health planning talent. An alternative, therefore, is provided in the Committee bill which authorizes project grants to State Comprehensive Health Planning agencies for the purpose of assisting such handicapped areas in their comprehensive health planning. Project grants to State Comprehensive Health Planning agencies would provide such areas the opportunity to organize their own comprehensive health planning councils and to have the benefit of expertise from the State staff. The intent of such grants would be to assist areas of the State not having an opportunity to be served by areawide planning agencies to do their own planning, rather than to have the State plan for them.

Present law requires the establishment of health planning councils with certain types of representation as a condition for awarding State comprehensive health planning grants but does not statutorily require the same of areawide comprehensive health planning grants, although the concept is essentially equally applicable. This Bill would remedy this inadequacy in present law by requiring the establishment of areawide health planning councils with representation generally comparable to that required for State health planning councils.

Training, Studies, and Demonstration—section 314(c).—The Committee bill extends for five years and increases the authorization levels for programs supporting training, studies or demonstrations which will help to improve or make more effective comprehensive health planning throughout the Nation. The committee understands that training funds may be made available under this authorization to begin to develop the statistical manpower essential to the successful design and implementation of the cooperative health information and statistics system for which initial authority is granted under section 210(b) of the bill.

The bill would authorize \$8,000,000 for fiscal year 1971, \$9,000,000 for fiscal year 1972, \$10,000,000 for fiscal year 1973, \$11,000,000 for fiscal year 1974, and \$12,000,000 for fiscal year 1975.

Public Health Services—section 314(d).—The bill would authorize \$130,000,000 for fiscal year 1971, \$145,000,000 for fiscal year 1972, \$165,000,000 for fiscal year 1973, \$180,000,000 for fiscal year 1974, and \$200,000,000 for fiscal year 1975 so as to continue supporting state departments of Health and Mental Health in the provision of needed public health services.

Health Services Development—section 314(e).—The bill would authorize \$109,500,000 for fiscal year 1971, \$135,000,000 for fiscal year 1972, \$157,000,000 for fiscal year 1973, \$186,000,000 for fiscal year 1974, and \$213,000,000 for fiscal year 1975 to improve and enhance the program of project grants for health services development.

The Committee finds that the Department of Health, Education and Welfare will assume support for selected, mature neighborhood health service centers previously funded by the Office of Economic Opportunity. The addition of these health center programs, created originally to serve poor populations, is consistent with the Department's commitment and plan to develop systems of primary health care for the poor and to work toward extending that strategy to the

health care needs of the total population. President Nixon transferred \$30,000,000 in his budget this year from the Office of Economic Opportunity to the Department of Health, Education and Welfare for this purpose.

The Committee finds, however, that whereas the Office of Economic Opportunity is authorized to pay, as part of the costs of such projects, equity requirements and amortization of loans on facilities, the Department of Health, Education and Welfare lacks any clear such authorization under section 314. S. 3355 will remedy this barrier to the transfer of appropriate projects by authorizing the payment of equity requirements and amortization of loans on facilities as part of the costs of project grants for comprehensive health services. Equity requirements includes the difference between the total estimated replacement cost of a facility, including movable equipment, and the mortgage amount. Amortization of loans on facilities includes principle and interest costs, mortgage insurance premiums, if any, real estate taxes, if any, insurance premiums, special assessments and ground rents, if any.

The Committee believes that the present provision in the law requiring Project Grants for Health Services Development to be in accordance with such plans as have been developed pursuant to State comprehensive health planning does not provide Area-wide comprehensive health planning agencies an opportunity to review and comment on applications for project grants for health services development in their respective areas. The Committee's bill remedies that situation by affording the area-wide planning agency an opportunity to review and comment on applications for grants for health services development in their respective areas.

The Committee notes with concern the fact that a large proportion of the programs funded under section 314(e) continue to be too narrowly focused rather than focused upon the broader area of the organization and delivery of health services. In large part, of course, this is attributable to the fact that the states have not been as willing as the Congress had hoped, in funding these vitally important though narrower projects with funds made available under the bloc grant program, 314(d). The Congress is in the process of responding to this problem. The Senate has passed and the House will soon take up the Communicable Disease Control and Vaccination Assistance Amendments of 1969 which, if enacted, would authorize separate categorical project grant authority for these programs. At that time the Committee intends that HEW will, as rapidly as possible, insure that the projects funded under section 314(e) be primarily intended to grapple with the organization and delivery of comprehensive health services.

6. Authorize in appropriate and limited circumstances the joint administration of projects involving more than one of the programs included in S. 3355 as reported.

As attention is increasingly focused upon various critical areas of need for health services, it can be anticipated that funds to deal with these needs will be converging from several sources of support. In the committee bill, for example, matters such as medical care delivery systems development and coordination, home health services, and manpower training and utilization are emphasized under more than one program.

In order to facilitate and expedite joint administration of projects in which there are costs eligible for assistance from more than one program for which funds are authorized by the bill, a provision has been added authorizing the Secretary to promulgate regulations pursuant to which a single administrative unit may perform the necessary administrative functions for all the programs, reducing and simplifying the numbers and types of separate forms, reports and data requests which have to be submitted, and revising and making uniform any inconsistent or duplicative program requirements. The Secretary would not be authorized, however, to waive or suspend any requirement imposed by law or by any regulation required by law. Additionally, the bill limits the single administrative unit to either the unit which administers one of the programs covered by S. 3355 or the administrative unit charged with the supervision of two or more of such programs. Under current HEW organization that would have the effect of limiting the designation of such a unit to the Regional Medical Program Service, the Community Health Service, the National Center for Health Services Research and Development, or the Health Services and Mental Health Administration.

7. Require the Secretary of HEW to annually transmit to the Congress a report concerning the effectiveness of the programs contained in S. 3355 as well as a statement of the relationship between them and the financing of health services.

TITLE III

Title III of the bill would create a National Council on Health Policy. The Council would be modeled along the lines of the Council of Economic Advisers and the recently created Council on Environmental Quality. It would be located in the Executive Office of the President, and would consist of three full-time members appointed by the President with the advice and consent of the Senate.

The principal function of the Council would be to establish a national health policy for the United States, and to make recommendations to the President and Congress on methods to achieve the goals of the policy. The Council would provide new executive leadership at the national level in health affairs. As a high-level coordinator and policy-maker in the health field, the Council would study and evaluate health activities throughout the Federal, state, local and private sectors, and would suggest new programs and new approaches in all areas of health policy, such as research, facilities, services, manpower, and the organization, delivery, and financing of health care.

The committee bill would authorize the appropriation of \$300,000 for the operation of the Council for fiscal year 1971, \$500,000 for fiscal year 1972, and \$1,000,000 for each fiscal year thereafter.

The Committee believes that the creation of a National Council on Health Policy is overdue, especially in light of the tremendous growth of Federal health programs in recent years, and the lack of an adequate existing mechanism for setting national health policies and long-range goals.

Numerous bills have been introduced in past Congresses to create such a council. Although temporary, short-term groups, including

presidential commissions, *ad hoc* committees, and interagency committees have been created in the past to deal with specific problems in the health field, none of these groups has had the scope or the authority of the ongoing Council now recommended by the Committee in Title III.

In the current Congress, the extensive hearings and report of the Senate Subcommittee on Executive Reorganization and Government Research, chaired by Senator Abraham Ribicoff, have documented the confusing maze of existing Federal health programs and the absence of any effective national health policy. For example, the nation's highest health officer—the Assistant Secretary of HEW for Health Affairs—controls only 22% of HEW's total health expenditures of \$14 billion for fiscal year 1970, and only 16% of the total health expenditures of \$19 billion for all the 24 Federal departments and agencies engaged in health programs. As the result of its study, one of the subcommittee's principal recommendations was for the creation of a Council of Health Advisers, thereby giving new impetus to the movement for the creation of such a Council.

The Committee intends that the National Council on Health Policy would fulfill a function in the area of health affairs similar to the function now fulfilled by the Council of Economic Advisers in the area of economic affairs. Since its creation shortly after the Second World War, the Council of Economic Advisers has played a major coordinating and policy-making role in economic matters; it has established itself as a prestigious entity in the White House Office, distinct from the Departments of Treasury, Commerce, and Labor and the Federal Reserve Board, each of which also has an important role in economic affairs.

The Health Council recommended by the Committee would perform a corresponding function in health policy, and would establish itself as an entity distinct from the existing Federal departments and agencies with operating responsibilities in health affairs. Ideally, the annual report of the Health Council would become the same sort of major health event in the Nation that the annual report of the Council of Economic Advisers represents for the economy.

The Committee emphasizes that it views the role of the National Council on Health Policy as one of making reviews, evaluations, and recommendations. Those Federal departments and agencies—for example, HEW, the Veterans Administration, and the Department of Defense—with existing health programs would retain full control and direction of their programs, as well as the responsibility toward their particular beneficiaries set forth in their existing statutory authority.

The deepening health crisis in the Nation is in large part the result of the failure to create a coherent and coordinated national health policy, capable of defining the health needs of contemporary America, assessing our health resources, and proposing adequate health programs. The committee believes that the establishment of a National Health Council capable of setting and coordinating national health policy, is a necessary precondition if the nation is to bring order out of the current disarray of Federal health programs.

TITLE IV

Title IV of the bill would facilitate the group practice of medicine. It provides that the Secretary of Health, Education and Welfare may authorize carriers participating in Federal health benefit programs for Federal employees to issue contracts for prepaid group practice health services to any persons, whether or not such persons are Federal employees.

The purpose of Title IV is to promote the development and use of prepaid group practice, and thereby to make this innovative type of health care delivery system available to both consumers and physicians who desire to take advantage of it. The committee believes that prepaid group practice has become **one of** the most promising developments for improving the delivery of high quality medical care in the United States. Many health experts regard prepaid group practice as the health care of the future in America. They believe it is the best available method to achieve more effective and more economical use of our scarce professional personnel and expensive health facilities.

Although the principles of group practice have been carefully evolved and tested in many parts of the country during the past three decades, it is only recently that national interest has been generated in the idea. The primary reason for this new interest is the realization that the nation's current health crisis is growing more serious, and that better methods for the organization and delivery of health care must be developed if we are to meet the crisis.

One of the keys to the success of prepaid group practice is alleviating the need for hospital care and emphasizing the need for preventive care. Prepaid coverage of physical examinations, immunizations and virtually all appropriate out-patient diagnostic and therapeutic procedures enhances the prospects for prevention or early detection of illness.

The Kaiser-Permanente Medical Care Program in California, for example, has recently reported substantial savings in the costs of health care for persons enrolled in its plan, in terms of number of hospital admissions and lower patient costs. Overall, the various Kaiser plans now have two million subscribers in six states, served by 52 out-patient centers and 21 hospitals. The comprehensive care provided by the Kaiser plans is made available at a cost as low as \$140 per capita, or about 20-30% less than the cost of comparable health care in most other parts of the country. Income from the Kaiser plans has provided nearly \$250 million worth of physical facilities and equipment. In addition, the income provides funds for teaching, training and research, and pays competitive incomes to about 2,000 physicians and 15,000 non-physician employees.

The fact is, however, that in about twenty states today, prepaid group practice is inhibited by substantial obstacles, created by local laws and regulations. Among these obstacles, as identified by the Report of the National Conference on Group Practice sponsored by the Department of Health, Education and Welfare in 1967, are the following:

Limitations on the right of consumers or physicians to organize group practice programs.

Limitations on the right to establish prepayment or other organizations to offer comprehensive health benefits.

Limitations on the right to combine group practice with prepayment to provide comprehensive health benefit programs.

Limitations on the geographical scope of group practice programs.

The approach adopted by the committee in Title IV is designed to overcome some of the existing restrictions on prepaid group practice. Under the provision of section 401, the Secretary of Health, Education, and Welfare may authorize any carrier participating in the Federal employees health benefits program under Title 5 of the United States Code to issue group practice contracts that meet the requirements of the section.

Thus, for example, any carrier participating, either directly or through reinsurance, in the service benefit plan, the indemnity plan, employee organization plans, or comprehensive medical plans under 5 U.S.C. §903 for Federal employees could be authorized by the Secretary of HEW to issue group practice prepayment plans for other persons, whether or not such persons are Federal employees. Similarly, carriers participating in health benefit programs under Public Law 86-724 for retired Federal employees could also be authorized to issue group practice prepayment plans.

Subsections (b) and (c) of section 401 provide a definition of group practice and are based on the definitions in Title V of the Model Cities Act of 1966 (P.L. 89-754), which established a program of Federal mortgage insurance for group practice facilities.

In general, group practice programs under the Committee bill must meet three basic criteria:

(1) The physicians in the group must be "full time" practitioners—that is, the principal professional activity of the members of the group as a whole must be as participants in the group arrangement and the group must practice primarily in a group practice facility or facilities.

(2) The group must offer comprehensive medical care in a diversification of medical specialties. Each group must contain an appropriate balance of family physicians and specialists. In general, the committee intends that a group should have at least a general practitioner and representatives of each of the five principal medical specialties: surgery, obstetrics, internal medicine, pediatrics, and ear-nose-throat. Comprehensive medical services would include preventive, diagnostic and therapeutic medical services on a prepaid basis. However, comprehensive medical services need not necessarily include dental, mental health, hospital, optometric or nursing home services, or equipment and other supplies, except as such services and supplies may be provided at the option of the carrier, with or without copayment as permitted by regulations of the Secretary.

(3) The members of the group must pool the income from their medical practice as members of the group, and must redistribute it among themselves according to a prearranged plan. Or, the members of the group may enter into an employment arrangement with a group practice unit or organization for the provision of their services.

The authorization given to the Secretary in Title IV of the committee bill is intended to encourage those group practice programs that have the greatest potential for improving the delivery of health care. One of the most significant aspects of the committee bill is that it will encourage greater participation by the private, or "voluntary", health sector in developing innovative approaches to health care. Such

encouragement is especially needed at this time, when appropriations for Federal health programs are being substantially curtailed.

An example of the type of innovation envisaged by the Committee under Title IV is the program now being developed in Columbia, Maryland, where John Hopkins University Medical School and the Connecticut General Life Insurance Company have joined together to form a prepaid group practice plan for Columbia residents. The company has already provided \$3,750,000 in mortgage financing for the construction of permanent medical facilities in Columbia, including a 60-bed hospital scheduled to open next year. In addition, the company is underwriting all the initial development deficits for the plan, which are expected to total at least \$500,000.

There are many states today where this and other types of innovation by the private health sector could not be undertaken, even though physicians, medical schools, consumers, non-profit organizations, co-operatives, and private insurers would be ready and willing to develop them, given the opportunity. Title IV of the committee bill is intended to make the opportunity available.

COMMENTS APPLICABLE TO BOTH TITLES I AND II OF S. 3355

1. Home Health Care

Experience and recent research have shown that home health care programs can accelerate the rate of recovery from illness, can prevent or postpone disability, can reduce the time of hospitalization, and can achieve these results at lower costs than the same services provided in an institutional setting. Benefits to the patient are considerable: economically in terms of reduced cost of care and psychologically in terms of a comfortable recovery in a noninstitutional, familiar, home environment. Greater utilization of home care programs can also relieve overcrowding in hospitals, and can release sorely needed hospital beds for the patient awaiting elective surgery, as well as for the critically ill emergency case.

The Committee believes home health care has a great potential in alleviating some of the problems besetting the nation's health system. S. 3355 has provided for the inclusion of home health care programs in the development of Regional Medical Programs, State and area-wide health planning and research in the area of health services delivery. Amendments to Title IX emphasize that home health care is an important method of care in the critical diseases which are the major concern of Regional Medical Programs. Amendments to Sections 314 (a) and (b) identify home health care as a service that should be included in planning for health services at both the state and area level. Inclusion of home health care as a specific research area for research and development grants in health services under section 304, the Committee feels, will place home health care in its proper perspective as a full member of a comprehensive health care delivery system.

Treatment programs carried out through home health care services must be interrelated with other medical services of the community to be fully effective in improving health delivery systems. The Committee fully endorses the principle that any home health care treatment program must be initially prescribed by a physician and must be monitored on a continuous basis by a physician through direct personal contact with the patient.

2. Veterans' Administration Representation On Advisory Bodies

The bill provides for the membership (on an ex officio basis) of representatives of facilities of the Veterans Administration on advisory bodies to State Comprehensive Health Planning Agencies and to individual Regional Medical Programs as well as of the VA Chief Medical Director (on an ex officio basis) on the National Advisory Council for Regional Medical Programs.

The Committee feels that the hospital and other medical facilities of the Veterans' Administration have a vital interest in the development of the community's health resources, since their beneficiaries and their families are members of the community. In turn, the community's planning is incomplete if it does not take into account the services provided by the Veterans' Administration facilities.

Representation of VA facilities on these advisory bodies is not intended in any way to dilute the authority of community representatives in developing and administering health programs; nor is it intended to impose any restrictions on the VA medical system. The Committee's purpose in adopting these provisions is to foster communication and greater coordination between the medical facilities of the VA and the medical resources of the community.

In many instances, close involvement of VA facilities with community facilities and programs is already a fact, and has proven highly beneficial to all concerned, but in some areas these relationships are minimal or nonexistent.

Representation of the VA on the State health planning advisory councils should result in better coordination of planning for facilities construction, better planning for costly specialized medical units, greater ability to determine the state's competence to train medical personnel needed for its population as well as improving planning for the optimum delivery of health care to the state's residents. Informal methods of participation exist in VA-Comprehensive Health Planning relationships at the areawide level, and the Committee believes that this salutary trend can be expanded by the closer relations at the state level provided in the bill.

In Regional Medical Programs considerable progress has already been made in the participation of VA hospitals with local programs. The critical diseases which are the major concern of Regional Medical Programs are likewise major concerns of the VA medical system. Currently, 72 VA hospitals are already cooperating in Regional Medical Programs projects. The Committee believes further participation will be encouraged by VA facility representation on advisory groups to Regional Medical Programs.

CHANGES IN EXISTING LAW

In compliance with subsection 4 of rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT, AS AMENDED

TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC
HEALTH SERVICE

RESEARCH AND DEMONSTRATIONS RELATING TO HEALTH FACILITIES
AND SERVICES

SEC. 304. (a) (1) The Secretary is authorized—

[(1)] (A) to make grants to States, political subdivisions, universities, hospitals, and other public or nonprofit private agencies, institutions, or organizations for projects for the conduct of research, experiments, or demonstrations (and related training), and

[(2)] (B) to make contracts with public or private agencies, institutions, or organizations for the conduct of research, experiments, or demonstrations (and related training), relating to the development, utilization, quality, organization, and financing of services, facilities, and resources of hospitals, facilities for long-term care, or other medical facilities (including, for purposes of this section, facilities for the mentally retarded, as defined in the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963), agencies, institutions, or organizations or to development of new methods or improvement of existing methods of organizations, delivery, or financing of health services, including, among others—

[(A)] (i) projects for the construction of units of hospitals, facilities for long-term care, or other medical facilities which involve experimental architectural designs or functional layout or use of new materials or new methods of construction, the efficiency of which can be tested and evaluated, or which involve the demonstration or such efficiency, particularly projects which also involve research, experiments, or demonstrations relating to delivery of health services, and

[(B)] (ii) projects for development and testing of new equipment and systems, including automated equipment, and other new technology systems or concepts for the delivery of health services, and

[(C)] (iii) projects for research and demonstration in new careers in health manpower and new ways of educating and utilizing health manpower**].**, and

 (iiv) *projects for research, experiments, and demonstrations dealing with the effective combination or coordination of public, private, or combined public-private methods or systems for the delivery of health services at regional, State, or local levels, and*

 (v) *projects for research and demonstrations in the provision of home health services.*

[(b)] (2) Except where the Secretary determines that unusual circumstances make a larger percentage necessary in order to effectuate the purposes of **[this section]** *this subsection*, a grant or contract under **[this section]** *this subsection* with respect to any project for construc-

tion of a facility or for acquisition of equipment may not provide for payment of more than 50 per centum of so much of the cost of the facility or equipment as the Secretary determines is reasonably attributable to research, experimental, or demonstration purposes. The provisions of clause (5) of the third sentence of section 605(a) and such other conditions as the Secretary may determine shall apply with respect to grants or contracts under **[this section]** *this subsection* for projects for construction of a facility or for acquisition of equipment.

[(c)] (3)(A) Payments of any grants or under any contracts under **[this section]** *this subsection* may be made in advance or by way of reimbursement, and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of **[this section]** *this subsection*.

(B) *The amounts otherwise payable to any person under a grant or contract made under this subsection shall be reduced by—*

(i) *amounts equal to the fair market value of any equipment or supplies furnished to such person by the Secretary for the purpose of carrying out the project with respect to which such grant or contract is made, and*

(ii) *amounts equal to the pay, allowances, traveling expenses, and related personnel expenses attributable to the performance of services by an officer or employee of the Government in connection with such project, if such officer or employee was assigned or detailed by the Secretary to perform such services, but only if such person requested the Secretary to furnish such equipment or supplies, or such services, as the case may be.*

Systems Analysis of Alternative National Health Care Plans

(b)(1)(A) *The Secretary shall develop, through utilization of the systems analysis method, alternative plans for health care systems designed adequately to meet the health needs of the American people. For purposes of the preceding sentence, the systems analysis method means the analytical method by which alternative means of obtaining a desired result or goal is associated with the costs and benefits involved.*

(B) *The Secretary shall complete the development of the alternative plans referred to in subparagraph (A), within such period as may be necessary to enable him to submit to the Congress not later than June 30, 1971, a report thereon which shall describe each plan so developed in terms of—*

- (i) *the number of people who would be covered under the plan;*
- (ii) *the kind and type of health care which would be covered under the plan;*
- (iii) *the cost involved in carrying out the plan and how such costs would be financed;*
- (iv) *the number of additional physicians and other health care personnel and the number and type of health care facilities needed to enable the plan to become fully effective;*
- (v) *the new and improved methods, if any, of delivery of health care services which would be developed in order to effectuate the plan;*
- (vi) *the accessibility of the benefits of such plan to various socio-economic classes of persons;*
- (vii) *the relative effectiveness and efficiency of such plan as compared to existing means of financing and delivering health care; and*

(viii) the legislative, administrative, and other actions which would be necessary to implement the plan.

(C) In order to assure that the advice and services of experts in the various fields concerned will be obtained in the alternative plans authorized by this paragraph and that the purposes of this paragraph will fully be carried out—

(i) the Secretary shall utilize, whenever appropriate, personnel from the various agencies, bureaus, and other departmental subdivisions of the Department of Health, Education, and Welfare;

(ii) the Secretary is authorized, with the consent of the head of the department or agency involved, to utilize (on a reimbursable basis) the personnel and other resources of other departments and agencies of the Federal Government; and

(iii) the Secretary is authorized to consult with appropriate State or local public agencies, private organizations, and individuals.

Cost and Coverage Report on Existing Legislative Proposal.

(2)(A) The Secretary shall, in accordance with this paragraph, conduct a study of each legislative proposal which is introduced in the Senate or the House of Representatives during the Ninety-first Congress, and which undertakes to establish a national health insurance plan or similar plan designed to meet the needs of health insurance or for health services of all or the overwhelming majority of the people of the United States.

(B) In conducting such study with respect to each such legislative proposal, the Secretary shall evaluate and analyze such proposal with a view to determining—

(i) the costs of carrying out the proposal; and

(ii) the adequacy of the proposal in terms of (I) the portion of the population covered by the proposal, (II) the type health care provided, paid for, or insured against under the proposal, (III) whether, and if so, to what extent, the proposal provides for the development of new and improved methods for the delivery of health care and services.

(C) Not later than December 31, 1970, the Secretary shall submit to the Congress a report on each legislative proposal which he has been directed to study under this paragraph, together with an analysis and evaluation of such proposal.

(c)(1) There are authorized to be appropriated for payment of grants or under contracts under subsection (a), and for purposes of carrying out the provisions of subsection (b), \$84,000,000 for the fiscal year ending June 30, 1971 (of which not less than \$4,000,000 shall be available only for purposes of carrying out the provisions of subsection (b)), \$85,000,000 for the fiscal year ending June 30, 1972, \$94,000,000 for the fiscal year ending June 30, 1973, \$110,000,000 for the fiscal year ending June 30, 1974, and \$130,000,000 for the fiscal year ending June 30, 1975.

(2) In addition to the funds authorized to be appropriated under paragraph (1) to carry out the provisions of subsection (b) there are hereby authorized to be appropriated to carry out such provisions for each fiscal year such sums as may be necessary.

THE NATIONAL HEALTH SURVEYS AND STUDIES

SEC. 305. (a) The Surgeon General is authorized (1) to make, by sampling or other appropriate means, surveys and special studies

of the population of the United States to determine the extent of illness and disability and related information such as: (A) the number, age, sex, ability to work or engage in other activities, and occupation or activities of persons afflicted with chronic or other disease or injury or handicapping condition; (B) the type of disease or injury or handicapping condition of each person so afflicted; (C) the length of time that each such person has been prevented from carrying on his occupation or activities; (D) the amounts and types of services received for or because of such conditions; **[and]** (E) the economic and other impacts of such conditions; (F) *health care resources*; (G) *environmental and social health hazards*; and (H) *family formation growth and dissolution*; and (2) in connection therewith, to develop and test new or improved methods for obtaining current data on illness and disability and related information. *Except to the extent otherwise provided by regulations of the Secretary, no information obtained as a result of surveys and studies conducted pursuant to this subsection shall be disclosed or used for any purpose other than the statistical purposes for which it was supplied; and no such information relating to any particular establishment or person shall be published in a form which identifies such establishment or person unless such establishment or person consents to the publication of such information in such form.*

(b) *The Secretary is authorized directly, or by contract to conduct research and demonstrations, and to make evaluations, relating to the design and implementation of a cooperative system for producing comparable and uniform health information and statistics at the Federal, State, and local levels.*

[(b)] (c) The Surgeon General is authorized, at appropriate intervals, to make available, through publications and otherwise, to any interested governmental or other public or private agencies, organizations, or groups, or to the public, the results of surveys or studies made pursuant to subsection (a).

[(c)] (d) For each fiscal year beginning after June 30, 1956, there are authorized to be appropriated such sums as the Congress may determine for carrying out the provisions of this section.

[(d)] (e) To assist in carrying out the provisions of this section the Surgeon General is authorized and directed to cooperate and consult with the Departments of Commerce and Labor and any other interested Federal Departments or agencies and with State health departments. For such purpose he shall utilize insofar as possible the services or facilities of any agency of the Federal Government and, without regard to section 3709 of the Revised Statutes, as amended, of any appropriate State or other public agency, and may, without regard to section 3709 of the Revised Statutes, as amended, utilize the services or facilities of any private agency, organization, group, or individual, in accordance with written agreements between the head of such agency, organization, or group, or such individual and the Secretary of Health, Education, and Welfare. Payment, if any, for such services or facilities shall be made in such amounts as may be provided in such agreement.

* * * * *

Sec. 310a. For the purpose of facilitating the administration of, and expediting the carrying out of the purposes of, the programs established by title IX and sections 304, 314(a), 314(b), 314(c), 314(d), and 314(e) of this Act in situations in which grants are sought or made under two or

more of such programs with respect to a single project, the Secretary is authorized to promulgate regulations—

(1) under which the administrative functions under such programs with respect to such project will be performed by a single administrative unit which is the administrative unit charged with the administration of any of such programs or is the administrative unit charged with the supervision of two or more of such programs;

(2) designed to reduce the number of applications, reports, and other materials required under such programs to be submitted with respect to such project, and otherwise to simplify, consolidate, and make uniform (to the extent feasible), the data and information required to be contained in such applications, reports, and other materials; and

(3) under which inconsistent or duplicative requirements imposed by such programs will be revised and made uniform with respect to such project;

except that nothing in this section shall be construed to authorize the Secretary to waive or suspend, with respect to any such project, any requirement with respect to any of such programs if such requirement is imposed by law or by any regulation required by law.

310b. On or before January 1 of each year, the Secretary shall transmit to the Congress a report of the activities carried on under the provisions of title IX of this Act and sections 304, 305, 314(a), 314(b), 314(c), 314(d), and 314(e) of this title together with (1) an evaluation of the effectiveness of such activities in improving the efficiency and effectiveness of the research, planning, and delivery of health services in carrying out the purposes for which such provisions were enacted, (2) a statement of the relationship between Federal financing and financing from other sources of the activities undertaken pursuant to such provisions (including the possibilities for more efficient support of such activities through use of alternate sources of financing after an initial period of support under such provisions), and (3) such recommendations with respect to such provisions as he deems appropriate.

PART B—FEDERAL-STATE COOPERATION

IN GENERAL

SEC. 311. (a) The Surgeon General is authorized to accept from State and local authorities any assistance in the enforcement of quarantine regulations made pursuant to this Act which such authorities may be able and willing to provide. The Surgeon General shall also assist States and their political subdivisions in the prevention and suppression of communicable diseases, shall cooperate with and aid State and local authorities in the enforcement of their quarantine and other health regulations and in carrying out the purposes specified in section 314, and shall advise the several States on matters relating to the preservation and improvement of the public health.

(b) The Surgeon General shall encourage cooperative activities between the States with respect to comprehensive and continuing planning as to their current and future health needs, the establishment and maintenance of adequate public health services, and otherwise carrying out the purposes of section 314. The Surgeon General is also authorized to train personnel for State and local health work.

(c) The Secretary may enter into agreements providing for cooperative planning between Public Health Service medical facilities and

community health facilities to cope with health problems resulting from disasters, and for participation by Public Health Service medical facilities in carrying out such planning. He may also, at the request of the appropriate State or local authority, extend temporary (not in excess of forty-five days) assistance to States or localities in meeting health emergencies of such a nature as to warrant Federal assistance. The Secretary may require such reimbursement of the United States for aid (other than planning) under the preceding sentences of this subsection as he may determine to be reasonable under the circumstances. Any reimbursement so paid shall be credited to the applicable appropriation of the Public Health Service for the year in which such reimbursement is received.

HEALTH CONFERENCES

SEC. 312. A conference of the health authorities of the several States shall be called annually by the Surgeon General. Whenever in his opinion the interests of the public health would be promoted by a conference, the Surgeon General may invite as many of such health authorities and officials of other State or local public or private agencies, institutions, or organizations to confer as he deems necessary or proper. Upon the application of health authorities of five or more States it shall be the duty of the Surgeon General to call a conference of all State and Territorial health authorities joining in the request. Each State represented at any conference shall be entitled to a single vote. Whenever at any such conference matters relating to mental health are to be discussed, the mental health authorities of the respective States shall be invited to attend.

(a) There shall be a collection of the statistics of the births and deaths in registration areas annually, the data for which shall be obtained only from and restricted to such registration records of such States and municipalities as in the discretion of the Secretary of Health, Education, and Welfare possess records affording satisfactory data in necessary detail, the compensation for the transcription of which shall not exceed 4 cents for each birth or death reported; or a minimum compensation of \$25 may be allowed in the discretion of the Secretary of Health, Education, and Welfare, in States or cities registering less than five hundred deaths or five hundred births during the preceding year.

COLLECTION OF VITAL STATISTICS

SEC. 313. To secure uniformity in the registration of mortality, morbidity, and vital statistics the Surgeon General shall prepare and distribute suitable and necessary forms for the collection and compilation of such statistics which shall be published as a part of the health reports published by the Surgeon General.

GRANTS TO STATES FOR COMPREHENSIVE STATE HEALTH PLANNING

SEC. 314. (a)(1) AUTHORIZATION.—In order to assist the States in comprehensive and continuing planning for their current and future health needs, the Surgeon General is authorized during the period beginning July 1, 1966, and ending [June 30, 1970], *June 30, 1975* to make grants to States which have submitted, and had approved by

the Surgeon General, State plans for comprehensive State health planning. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated \$2,500,000 for the fiscal year ending June 30, 1967, \$7,000,000 for the fiscal year ending June 30, 1968, \$10,000,000 for the fiscal year ending June 30, 1969, [and \$15,000,000 for the fiscal year ending June 30, 1970] \$15,000,000 for the fiscal year ending June 30, 1970, \$15,000,000 for the fiscal year ending June 30, 1971, \$17,000,000 for the fiscal year ending June 30, 1972, \$20,000,000 for the fiscal year ending June 30, 1973, \$30,000,000 for the fiscal year ending June 30, 1974, and \$35,000,000 for the fiscal year ending June 30, 1975.

(2) STATE PLANS FOR COMPREHENSIVE STATE HEALTH PLANNING.—

In order to be approved for purposes of this subsection, a State plan for comprehensive State health planning must—

(A) designate, or provide for the establishment of, a single State agency, which may be an interdepartmental agency, as the sole agency for administering or supervising the administration of the State's health planning functions under the plan;

(B) provide for the establishment of a State health planning council, which shall include representatives of [State and local agencies] *Federal, State, and local agencies (including as an ex officio member, if there is located in such State one or more hospitals or other health care facilities of the Veterans' Administration, the individual whom the Administrator of Veterans' Affairs shall have designated to serve on such council as the representative of the hospitals or other health care facilities of such Administration which are located in such State)* and nongovernmental organizations and groups concerned with health (*including representation of the regional medical program or programs within the State*) and of consumers of health services, to advise such State agency in carrying out its functions under the plan, and a majority of the membership of such council shall consist of representatives of consumers of health services;

(C) set forth policies and procedures for the expenditure of funds under the plan, which, in the judgment of the Surgeon General, are designed to provide for comprehensive State planning for health services (both public and private *and including home health care*), including the facilities and persons required for the provision of such services, to meet the health needs of the people of the State;

(D) provide for encouraging cooperative efforts among governmental or nongovernmental agencies, organizations and groups concerned with health services, facilities, or manpower, and for cooperative efforts between such agencies, organizations, and groups and similar agencies, organizations, and groups in the fields of education, welfare, and rehabilitation;

(E) contain or be supported by assurances satisfactory to the Surgeon General that the funds paid under this subsection will be used to supplement and, to the extent practicable, to increase the level of funds that would otherwise be made available by the State for the purpose of comprehensive health planning and not to supplant such non-Federal funds;

(F) provide such methods of administration (including methods relating to the establishment and maintenance of personnel stand-

ards on a merit basis, except that the Surgeon General shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Surgeon General to be necessary for the proper and efficient operation of the plan;

(G) provide that the State agency will make such reports, in such form and containing such information, as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General finds necessary to assure the correctness and verification of such reports;

(H) provide that the State agency will from time to time, but not less often than annually, review its State plan approved under this subsection and submit to the Surgeon General appropriate modifications thereof;

(I) effective July 1, 1968, (i) provide for assisting each health care facility in the State to develop a program for capital expenditures for replacement, modernization, and expansion which is consistent with an overall State plan developed in accordance with criteria established by the Secretary after consultation with the State which will meet the needs of the State for health care facilities, equipment, and services without duplication and otherwise in the most efficient and economical manner, and (ii) provide that the State agency furnishing such assistance will periodically review the program (developed pursuant to clause (i)) of each health care facility in the State and recommended appropriate modification thereof;

(J) provide for such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement of and accounting for funds paid to the State under this subsection; and

(K) contain such additional information and assurances as the Surgeon General may find necessary to carry out the purposes of this subsection.

(3)(A) STATE ALLOTMENTS.—From the sums appropriated for such purpose for each fiscal year, the several States shall be entitled to allotments determined, in accordance with regulations, on the basis of the population and the per capita income of the respective States; except that no such allotment to any State for any fiscal year shall be less than 1 per centum of the sum appropriated for such fiscal year pursuant to paragraph (1). Any such allotment to a State for a fiscal year shall remain available for obligation by the State, in accordance with the provisions of this subsection and the State's plan approved thereunder, until the close of the succeeding fiscal year.

(B) The amount of any allotment to a State under subparagraph (A) for any fiscal year which the Surgeon General determines will not be required by the State, during the period for which it is available, for the purposes for which allotted shall be available for reallocation by the Surgeon General from time to time, on such date or dates as he may fix, to other States with respect to which such a determination has not been made, in proportion to the original allotments to such States under subparagraph (A) for such fiscal year, but with such proportionate amount for any of such other States being reduced to the extent it exceeds the sum the Surgeon General estimates such State needs and will be able to use during such period; and the total

of such reductions shall be similarly reallocated among the States whose proportionate amounts were not so reduced. Any amount so reallocated to a State from funds appropriated pursuant to this subsection for a fiscal year shall be deemed part of its allotment under subparagraph (A) for such fiscal year.

(4) **PAYMENTS TO STATES.**—From each State's allotment for a fiscal year under this subsection, the State shall from time to time be paid the Federal share of the expenditures incurred during that year or the succeeding year pursuant to its State plan approved under this subsection. Such payments shall be made on the basis of estimates by the Surgeon General of the sums the State will need in order to perform the planning under its approved State plan under this subsection, but with such adjustments as may be necessary to take account of previously made underpayments or overpayments. The "Federal share" for any State for purposes of this subsection shall be all, or such part as the Surgeon General may determine, of the cost of such planning, except that in the case of the allotments for the fiscal year ending June 30, 1970, it shall not exceed 75 per centum, of such cost.

PROJECT GRANTS FOR AREAWIDE HEALTH PLANNING

(b)(1)(A) The Surgeon General is authorized, during the period beginning July 1, 1966, and ending **[June 30, 1970]** *June 30, 1975*, to make, with the approval of the State agency administering or supervising the administration of the State plan approved under subsection (a), project grants to any other public or nonprofit private agency or organization (but with appropriate representation of the interests of local government where the recipient of the grant is not a local government or combination thereof or an agency of such government or combination) to cover not to exceed 75 per centum of the costs of projects for developing (and from time to time revising) comprehensive regional, metropolitan area, or other local area plans for coordination of existing and planned health services, including the facilities and persons required for provision of such services *and including the provision of such services through home health care*; except that in the case of project grants made in any State prior to July 1, 1968, approval of such State agency shall be required only if such State has such a State plan in effect at the time of such grants. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated \$5,000,000 for the fiscal year ending June 30, 1967, \$7,500,000 for the fiscal year ending June 30, 1968, \$10,000,000 for the fiscal year ending June 30, 1969, **[and \$15,000,000 for the fiscal year ending June 30, 1970]** *\$15,000,000 for the fiscal year ending June 30, 1970, \$20,000,000 for the fiscal year ending June 30, 1971, \$30,000,000 for the fiscal year ending June 30, 1972, \$40,000,000 for the fiscal year ending June 30, 1973, \$50,000,000 for the fiscal year ending June 30, 1974, and \$60,000,000 for the fiscal year ending June 30, 1975.*

(B) Project grants may be made by the Secretary under subparagraph (A) to the State agency administering or supervising the administration of the State plan approved under subsection (a) with respect to a particular region or area, but only if (i) no application for such a grant with respect to such region or area has been filed by any other agency or organization qualified to receive such a grant, and (ii) such State agency certifies, and

the Secretary finds, that ample opportunity has been afforded to qualified agencies and organizations to file application for such a grant with respect to such region or area and that it is improbable that, in the foreseeable future, any agency or organization which is qualified for such a grant will file application therefor.

(2) In order to be approved under this subsection, an application for a grant under this subsection must contain or be supported by reasonable assurances that there has been or will be established, in or for the area with respect to which such grant is sought, an areawide health planning council. The membership of such council shall include representatives of public, voluntary, and nonprofit private agencies, institutions, and organizations concerned with health (including representatives of the interests of local government, of the regional medical program for such area, and of consumers of health services). A majority of the members of such council shall consist of representatives of consumers of health services.

PROJECT GRANTS FOR TRAINING, STUDIES, AND DEMONSTRATIONS

(c) The Surgeon General is also authorized, during the period beginning July 1, 1966, and ending [June 30, 1970] June 30, 1975, to make grants to any public or nonprofit private agency, institution, or other organization to cover all or any part of the cost of projects for training, studies, or demonstrations looking toward the development of improved or more effective comprehensive health planning throughout the Nation. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated \$1,500,000 for the fiscal year ending June 30, 1967, \$2,500,000 for the fiscal year ending June 30, 1968, \$5,000,000 for the fiscal year ending June 30, 1969, [and \$7,500,000 for the fiscal year ending June 30, 1970] \$7,500,000 for the fiscal year ending June 30, 1970, \$8,000,000 for the fiscal year ending June 30, 1971, \$9,000,000 for the fiscal year ending June 30, 1972, \$10,000,000 for the fiscal year ending June 30, 1973, \$11,000,000 for the fiscal year ending June 30, 1974, and \$12,000,000 for the fiscal year ending June 30, 1975.

GRANTS FOR COMPREHENSIVE PUBLIC HEALTH SERVICES

(d)(1) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated \$70,000,000 for the fiscal year ending June 30, 1968, \$90,000,000 for the fiscal year ending June 30, 1969, [and \$100,000,000 for the fiscal year ending June 30, 1970], \$100,000,000 for the fiscal year ending June 30, 1970, \$130,000,000 for the fiscal year ending June 30, 1971, \$145,000,000 for the fiscal year ending June 30, 1972, \$165,000,000 for the fiscal year ending June 30, 1973, \$180,000,000 for the fiscal year ending June 30, 1974, and \$200,000,000 for the fiscal year ending June 30, 1975 to enable the Surgeon General to make grants to State health or mental health authorities to assist the States in establishing and maintaining adequate public health services, including the training of personnel for State and local health work. The sums so appropriated shall be used for making payments to States which have submitted, and had approved by the Surgeon General, State plans for provision of public health services, except that, for any fiscal year ending after June 30, 1968, such portion of such sums as the Secretary may determine, but not exceeding 1 per centum thereof, shall be available to the Secretary for evaluation (directly or by grants

or contracts) of the program authorized by this subsection and the amount available for allotments hereunder shall be reduced accordingly.

(2) STATE PLANS FOR PROVISION OF PUBLIC HEALTH SERVICES.—In order to be approved under this subsection, a State plan for provision of public health services must—

(A) provide for administration or supervision of administration by the State health authority or, with respect to mental health services, the State mental health authority;

(B) set forth the policies and procedures to be followed in the expenditure of the funds paid under this subsection;

(C) contain or be supported by assurances satisfactory to the Surgeon General that (i) the funds paid to the State under this subsection will be used to make a significant contribution toward providing and strengthening public health services in the various political subdivisions in order to improve the health of the people; (ii) such funds will be made available to other public or nonprofit private agencies, institutions, and organizations, in accordance with criteria which the Surgeon General determines are designed to secure maximum participation of local, regional, or metropolitan agencies and groups in the provision of such services; and (iii) such funds will be used to supplement and, to the extent practical, to increase the level of funds that would otherwise be made available for the purposes for which the Federal funds are provided and not to supplant such non-Federal funds;

(D) provide for the furnishing of public health services under the State plan in accordance with such plans as have been developed pursuant to subsection (a);

(E) provide that public health services furnished under the plan will be in accordance with standards prescribed by regulations, including standards as to the scope and quality of such services;

(F) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Surgeon General shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Surgeon General to be necessary for the proper and efficient operation of the plan;

(G) provide that the State health authority or, with respect to mental health services, the State mental health authority, will from time to time, but not less often than annually, review and evaluate its State plan approved under this subsection and submit to the Surgeon General appropriate modifications thereof;

(H) provide that the State health authority or, with respect to mental health services, the State mental health authority, will make such reports, in such form and containing such information, as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General finds necessary to assure the correctness and verification of such reports;

(I) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of and accounting for funds paid to the State under this subsection; and

(J) contain such additional information and assurances as the Surgeon General may find necessary to carry out the purposes of this subsection.

(3) **STATE ALLOTMENTS.**—From the sums appropriated to carry out the provisions of this subsection the several States shall be entitled for each fiscal year to allotments determined, in accordance with regulations, on the basis of the population and financial need of the respective States, except that no State's allotment shall be less for any year than the total amounts allotted to such State under formal grants for cancer control, plus other allotments under this section, for the fiscal year ending June 30, 1967.

(4)(A) **PAYMENTS TO STATES.**—From each State's allotment under this subsection for a fiscal year, the State shall be paid the Federal share of the expenditures incurred during such year under its State plan approved under this subsection. Such payments shall be made from time to time in advance on the basis of estimates by the Surgeon General of the sums the State will expend under the State plan, except that such adjustments as may be necessary shall be made on account of previously made underpayments or overpayments under this subsection.

(B) For the purpose of determining the Federal share for any State, expenditures by nonprofit private agencies, organizations, and groups shall, subject to such limitations and conditions as may be prescribed by regulations, be regarded as expenditures by such State or a political subdivision thereof.

(5) **FEDERAL SHARE.**—The "Federal share" for any State for purposes of this subsection shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the United States; except that in no case shall such percentage be less than 33½ per centum or more than 66½ per centum, and except that the Federal share for the Commonwealth of Puerto Rico, Guam, American Samoa, the Trust Territory of the Pacific Islands, and the Virgin Islands shall be 66½ per centum.

(6) **DETERMINATION OF FEDERAL SHARES.**—The Federal shares shall be determined by the Surgeon General between July 1 and September 1 of each year, on the basis of the average per capita incomes of each of the States and of the United States for the most recent year for which satisfactory data are available from the Department of Commerce, and such determination shall be conclusive for the fiscal year beginning on the next July 1. The populations of the several States shall be determined on the basis of the latest figures for the population of the several States available from the Department of Commerce.

(7) **ALLOCATION OF FUNDS WITHIN THE STATES.**—At least 15 per centum of a State's allotment under this subsection shall be available only to the State mental health authority for the provision under the State plan of mental health services. Effective with respect to allotments under this subsection for fiscal years ending after June 30, 1968, at least 70 per centum of such amount reserved for mental health services and at least 70 per centum of the remainder of a State's allotment under this subsection shall be available only for the provision under the State plan of services in communities of the State.

PROJECT GRANTS FOR HEALTH SERVICES DEVELOPMENT

(e) There are authorized to be appropriated \$90,000,000 for the fiscal year ending June 30, 1968, \$95,000,000 for the fiscal year ending June 30, 1969, [and \$80,000,000 for the fiscal year ending June 30, 1970], \$80,000,000 for the fiscal year ending June 30, 1970, \$109,500,000 for the fiscal year ending June 30, 1971, \$135,000,000 for the fiscal year ending June 30, 1972, \$157,000,000 for the fiscal year ending June 30, 1973, \$186,000,000 for the fiscal year ending June 30, 1974, and \$213,000,000 for the fiscal year ending June 30, 1975 for grants to any public or nonprofit private agency, institution, or organization to cover part of the cost (including equity requirements of and amortization of loans for facilities) of (1) providing services (including related training) to meet health needs of limited geographic scope or of specialized regional or national significance, or (2) developing and supporting for an initial period new programs of health services (including related training). Such grants may be made pursuant to clause (1) or (2) of the preceding sentence with respect to projects involving the furnishing of public health services only if such services are provided in accordance with such plans as have been developed pursuant to subsection (a). [For any fiscal year ending after June 30, 1968, such portion of the appropriations for grants under this subsection as the Secretary may determine, but not exceeding 1 per centum thereof, shall be available to the Secretary for evaluation (directly or by grants or contracts) of the program authorized by this subsection.] *Grants under this subsection shall be made only upon applications therefor which are approved by the Secretary, and the Secretary may not approve any application for any grant under this subsection with respect to any area unless he is satisfied (on the basis of evidence contained in or submitted in connection with such application) that reasonable opportunity for review of and comment on such application has been provided (i) to the agency or organization referred to in subsection (b) which is responsible for the development, for such area, of a comprehensive regional, metropolitan, or other area plans for coordination of existing and planned health services, or (ii) if there is no such agency or organization, to such other public or nonprofit private agency (if any) which is determined (in accordance with regulations of the Secretary) to be performing, for the area with respect to which such grant is requested, health planning functions similar to those performed by an agency or organization referred to in subsection (b) which is responsible for the development of comprehensive regional, metropolitan, or other area plans for coordination of existing and planned health services.*

INTERCHANGE OF PERSONNEL WITH STATES

(f)(1) For the purposes of this subsection, the term "State" means a State or a political subdivision of a State, or any agency of either of the foregoing engaged in any activities related to health or designated or established pursuant to subparagraph (A) of paragraph (2) of subsection (a); the term "Secretary" means (except when used in paragraph (3)(D)) the Secretary of Health, Education, and Welfare; and the term "Department" means the Department of Health, Education, and Welfare.

(2) The Secretary is authorized, through agreements or otherwise, to arrange for assignment of officers and employees of States to the

Department and assignment to States of officers and employees in the Department engaged in work related to health, for work which the Secretary determines will aid the Department in more effective discharge of its responsibilities in the field of health as authorized by law, including cooperation with States and the provision of technical or other assistance. The period of assignment of any officer or employee under an arrangement shall not exceed two years.

(3)(A) Officers and employees in the Department assigned to any State pursuant to this subsection shall be considered, during such assignment, to be (i) on detail to a regular work assignment in the Department, or (ii) on leave without pay from their positions in the Department.

(B) Persons considered to be so detailed shall remain as officers or employees, as the case may be, in the Department for all purposes, except that the supervision of their duties during the period of detail may be governed by agreement between the Department and the State involved.

(C) In the case of persons so assigned and on leave without pay—

(i) if the rate of compensation (including allowances) for their employment by the State is less than the rate of compensation (including allowances) they would be receiving had they continued in their regular assignment in the Department, they may receive supplemental salary payments from the Department in the amount considered by the Secretary to be justified, but not at a rate in excess of the difference between the State rate and the Department rate; and

(ii) they may be granted annual leave and sick leave to the extent authorized by law, but only in circumstances considered by the Secretary to justify approval of such leave.

Such officers and employees on leave without pay shall, notwithstanding any other provision of law, be entitled—

(iii) to continuation of their insurance under the Federal Employees' Group Life Insurance Act of 1954, and coverage under the Federal Employees Health Benefits Act of 1959, so long as the Department continues to collect the employee's contribution from the officer or employee involved and to transmit for timely deposit into the funds created under such Acts the amount of the employee's contributions and the Government's contribution from appropriations of the Department; and

(iv) (I) in the case of commissioned officers of the Service to have their service during their assignment treated as provided in section 214(d) for such officers on leave without pay, or (II) in the case of other officers and employees in the Department, to credit the period of their assignment under the arrangement under this subsection toward periodic or longevity step increases and for retention and leave accrual purposes, and, upon payment into the civil service retirement and disability fund of the percentage of their State salary, and of their supplemental salary payments, if any, which would have been deducted from a like Federal salary for the period of such assignment and payment by the Secretary into such fund of the amount which would have been payable by him during the period of such assignment with respect to a like Federal salary, to treat (notwithstanding the provisions of the Independent Offices Appropriations Act, 1959, under the head 'Civil Service Retirement and Disability Fund')

their service during such period as service within the meaning of the Civil Service Retirement Act; except that no officer or employee or his beneficiary may receive any benefits under the Civil Service Retirement Act, the Federal Employees Health Benefits Act of 1959, or the Federal Employees' Group Life Insurance Act of 1954, based on service during an assignment hereunder for which the officer or employee or (if he dies without making such election) his beneficiary elects to receive benefits, under any State retirement or insurance law or program, which the Civil Service Commission determines to be similar. The Department shall deposit currently in the funds created under the Federal Employees' Group Life Insurance Act of 1954, the Federal Employees Health Benefits Act of 1959, and the civil service retirement and disability fund, respectively, the amount of the Government's contribution under these Acts on account of service with respect to which employee contributions are collected as provided in subparagraph (iii) and the amount of the Government's contribution under the Civil Service Retirement Act on account of service with respect to which payments (of the amount which would have been deducted under that Act) referred to in subparagraph (iv) are made to such civil service retirement and disability fund.

(D) Any such officer or employee on leave without pay (other than a commissioned officer of the Service) who suffers disability or death as a result of personal injury sustained while in the performance of his duty during an assignment hereunder, shall be treated, for the purposes of the Federal Employees' Compensation Act, as though he were an employee, as defined in such Act, who had sustained such injury in the performance of duty. When such person (or his dependents, in case of death) entitled by reason of injury or death to benefits under that Act is also entitled to benefits from a State for the same injury or death, he (or his dependents in case of death) shall elect which benefits he will receive. Such election shall be made within one year after the injury or death, or such further time as the Secretary of Labor may for good cause allow, and when made shall be irrevocable unless otherwise provided by law.

(4) Assignment of any officer or employee in the Department to a State under this subsection may be made with or without reimbursement by the State for the compensation (or supplementary compensation), travel and transportation expenses (to or from the place of assignment), and allowances, or any part thereof, of such officer or employee during the period of assignment, and any such reimbursement shall be credited to the appropriation utilized for paying such compensation, travel or transportation expenses, or allowances.

(5) Appropriations to the Department shall be available, in accordance with the standardized Government travel regulations or, with respect to commissioned officers of the Service, the joint travel regulations, for the expenses of travel of officers and employees assigned to States under an arrangement under this subsection on either a detail or leave-without-pay basis and, in accordance with applicable laws, orders, and regulations, for expenses of transportation of their immediate families and expenses of transportation of their household goods and personal effects in connection with the travel of such officers and employees to the location of their posts of assignment and their return to their official stations.

(6) Officers and employees of States who are assigned to the Department under an arrangement under this subsection may (A) be given appointments in the Department covering the periods of such assignments, or (B) be considered to be on detail to the Department. Appointments of persons so assigned may be made without regard to the civil service laws. Persons so appointed in the Department shall be paid at rates of compensation determined in accordance with the Classification Act of 1949, and shall not be considered to be officers or employees of the Department for the purposes of (A) the Civil Service Retirement Act, (B) the Federal Employees' Group Life Insurance Act of 1954, or (C) unless their appointments result in the loss of coverage in a group health benefits plan whose premium has been paid in whole or in part by a State contribution, the Federal Employees Health Benefits Act of 1959. State officers and employees who are assigned to the Department without appointment shall not be considered to be officers or employees of the Department, except as provided in subsection (7), nor shall they be paid a salary or wage by the Department during the period of their assignment. The supervision of the duties of such persons during the assignment may be governed by agreement between the Secretary and the State involved.

(7) (A) Any State officer or employee who is assigned to the Department without appointment shall nevertheless be subject to the provisions of sections 203, 205, 207, 208, and 209 of title 18 of the United States Code.

(B) Any State officer or employee who is given an appointment while assigned to the Department, or who is assigned to the Department without appointment, under an arrangement under this subsection, and who suffers disability or death as a result of personal injury sustained while in the performance of his duty during such assignment shall be treated, for the purpose of the Federal Employees' Compensation Act, as though he were an employee, as defined in such Act, who had sustained such injury in the performance of duty. When such person (or his dependents, in case of death) entitled by reason of injury or death to benefits under that Act is also entitled to benefits from a State for the same injury or death, he (or his dependents, in case of death) shall elect which benefits he will receive. Such election shall be made within one year after the injury or death, or such further time as the Secretary of Labor may for good cause allow, and when made shall be irrevocable unless otherwise provided by law.

(8) The appropriations to the Department shall be available, in accordance with the standardized Government travel regulations, during the period of assignment and in the case of travel to and from their places of assignment or appointment, for the payment of expenses of travel of persons assigned to, or given appointments by, the Department under an arrangement under this subsection.

(9) All arrangements under this subsection for assignment of officers or employees in the Department to States or for assignment of officers or employees of States to the Department shall be made in accordance with regulations of the Secretary.

GENERAL

(g) (1) All regulations and amendments thereto with respect to grants to States under subsection (a) shall be made after consultation with a conference of the State health planning agencies designated or

established pursuant to subparagraph (A) of paragraph (2) of subsection (a). All regulations and amendments thereto with respect to grants to States under subsection (d) shall be made after consultation with a conference of State health authorities and, in the case of regulations and amendments which relate to or in any way affect grants for services or other activities in the field of mental health, the State mental health authorities. Insofar as practicable, the Surgeon General shall obtain the agreement, prior to the issuance of such regulations or amendments, of the State authorities or agencies with whom such consultation is required.

(2) The Surgeon General, at the request of any recipient of a grant under this section, may reduce the payments to such recipient by the fair market value of any equipment or supplies furnished to such recipient and by the amount of the pay, allowances, traveling expenses, and any other costs in connection with the detail of an officer or employee to the recipient when such furnishing or such detail, as the case may be, is for the convenience of and at the request of such recipient and for the purpose of carrying out the State plan or the project with respect to which the grant under this section is made. The amount by which such payments are so reduced shall be available for payment of such costs (including the costs of such equipment and supplies) by the Surgeon General, but shall, for purposes of determining the Federal share under subsection (a) or (d), be deemed to have been paid to the State.

(3) Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the health authority or, where appropriate, the mental health authority of a State or a State health planning agency designated or established pursuant to subparagraph (A) of paragraph (2) of subsection (a), finds that, with respect to money paid to the State out of appropriations under subsection (a) or (d), there is a failure to comply substantially with either—

- (A) the applicable provisions of this section;
- (B) the State plan submitted under such subsection; or
- (C) applicable regulations under this section;

the Surgeon General shall notify such State health authority, mental health authority, or health planning agency, as the case may be, that further payments will not be made to the State from appropriations under such subsection (or in his discretion that further payments will not be made to the State from such appropriations for activities in which there is such failure), until he is satisfied that there will no longer be such failure. Until he is so satisfied, the Surgeon General shall make no payment to such State from appropriations under such subsection, or shall limit payment to activities in which there is no such failure.

(4) For the purposes of this section—

(A) The term "nonprofit" as applied to any private agency, institution, or organization means one which is a corporation or association, or is owned and operated by one or more corporations or associations, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual; and

(B) The term "State" includes the Commonwealth of Puerto Rico, Guam, American Samoa, the trust territory of the Pacific Islands, the Virgin Islands, and the District of Columbia and the term "United States" means the fifty States and the District of Columbia.

* * * * *

TITLE IX—EDUCATION, RESEARCH, TRAINING, AND DEMONSTRATIONS IN THE FIELDS OF HEART DISEASE, CANCER, [STROKE, AND RELATED DISEASES] *STROKE, KIDNEY DISEASE, AND OTHER MAJOR DISEASES AND CONDITIONS*

PURPOSES

SEC. 900. The purposes of this title are—

(a) through grants *and contracts*, to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training (including continuing education) and for [related demonstrations] *demonstrations* of patient care in the fields of heart disease, cancer, stroke, [and related diseases] *kidney disease, and other major diseases and conditions.*

(b) to afford to the medical profession and the medical institutions of the Nation, through such cooperative arrangements, the opportunity of making available to their patients the latest advances in the [diagnosis and treatment of these diseases] *prevention, diagnosis, and treatment (including treatment through home health care) of these diseases and conditions, and in the rehabilitation (including rehabilitation through home health care) of individuals suffering from these diseases and conditions; [and]*

(c) *to promote and foster regional cooperation among health care institutions and providers so as to strengthen and improve primary care and the relationship between specialized and primary care; and*

[(c)] (d) by these means, to improve generally [the health manpower and facilities available to the Nation] *the quality and and enhance the capacity of the health manpower and facilities available to the Nation and to improve health services for persons residing in areas with limited health services, and to accomplish these ends without interfering with the patterns, or the methods of financing, of patient care or professional practice, or with the administration of hospitals, and in cooperation with practicing physicians, medical center officials, hospital administrators, and representatives from appropriate voluntary health agencies.*

AUTHORIZATIONS OF APPROPRIATIONS

SEC. 901. (a) There are authorized to be appropriated \$50,000,000 for the fiscal year ending June 30, 1966, \$90,000,000 for the fiscal year ending June 30, 1967, \$200,000,000 for the fiscal year ending June 30, 1968, \$65,000,000 for the fiscal year ending June 30, 1969, [and \$120,000,000 for the next fiscal year, for grants] *\$120,000,000 for the fiscal year ending June 30, 1970, \$150,000,000 for the fiscal year ending June 30, 1971, \$200,000,000 for the fiscal year ending June 30, 1972, \$250,000,000 for the fiscal year ending June 30, 1973, and for each of the next two fiscal years, for grants to assist public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private institutions and agencies in planning, in conducting feasibility studies, and in operating pilot projects for the establishment, of regional medical programs of research, training, and demonstration activities for carrying out the purposes of this title.*

[Sums appropriated under this section for any fiscal year shall remain available for making such grants until the end of the fiscal year following the fiscal year for which the appropriation is made.] *Of the sums appropriated under this section for the fiscal year ending June 30, 1971, not more than \$15,000,000 shall be available for activities in the field of kidney disease.* For any fiscal year ending after June 30, 1969, such portion of the appropriations pursuant to this section as the Secretary may determine, but not exceeding 1 per centum thereof, shall be available to the Secretary for evaluation (directly or by grants or contracts) of the program authorized by this title.

(b) A grant under this title shall be for part or all of the cost of the planning or other activities with respect to which the application is made, except that any such grant with respect to construction of, or provision of built-in (as determined in accordance with regulations) equipment for, any facility may not exceed 90 per centum of the cost of such construction or equipment.

(c) Funds appropriated pursuant to this title shall not be available to pay the cost of hospital, medical, or other care of patients except to the extent it is, as determined in accordance with regulations, incident to those research, training, or demonstration activities which are encompassed by the purposes of this title. No patient shall be furnished hospital, medical, or other care at any facility incident to research, training, or demonstration activities carried out with funds appropriated pursuant to this title, unless he has been referred to such facility by a practicing physician or, where appropriate, a practicing dentist.

(d) Grants under this title to any agency or institution, or combination thereof, for a regional medical program may be used by it to assist in meeting the cost of participation in such program by any Federal hospital.

(e) *At the request of any recipient of a grant under this title, the payments to such recipient may be reduced by the fair market value of any equipment, supplies, or services furnished to such recipient and by the amount of the pay, allowance, traveling expenses, and any other costs in connection with the detail of an officer or employee to the recipient when such furnishing or such detail, as the case may be, is for the convenience of and at the request of such recipient and for the purpose of carrying out the regional medical program to which the grant or contract under this title is made.*

DEFINITIONS

SEC. 902. For the purposes of this title—

(a) the term "regional medical program" means a cooperative arrangement among a group of public or nonprofit private institutions or agencies engaged (i) in research, [training, diagnosis, and treatment relating to heart disease, cancer, or stroke, and, at the option of the applicant, related disease or diseases] *training, prevention, diagnosis, treatment, and rehabilitation (including home health care) relating to heart disease, cancer, stroke, or kidney disease, and, at the option of the applicant, other major diseases or conditions, or at the option of the applicant, (ii) in developing and demonstrating systems for organizing and delivering medical care, but only (I) with respect to an applicant which is engaged in one or more of the activities referred to in subclause (i), and (II) for any period of time,*

if prior to the commencement of such period the applicant has for a reasonable period of time engaged in one or more of the activities referred to in subclause (i); but only if such group—

(1) is situated within a geographic area, composed of any part or parts of any one or more States (which for purposes of this title includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Trust Territory of the Pacific Islands), which the [Surgeon General] *Secretary* determines, in accordance with regulations, to be appropriate for carrying out the purposes of this title;

(2) consists of one or more medical centers, one or more clinical research centers, and one or more hospitals; and

(3) has in effect cooperative arrangements among its component units which the [Surgeon General] *Secretary* finds will be adequate for effectively carrying out the purposes of this title.

(b) the term “medical center” means a medical school or other medical institution involved in postgraduate medical training and one or more hospitals affiliated therewith for teaching, research, and demonstration purposes.

(c) the term “clinical research center” means an institution (or part of an institution) the primary function of which is research, training of specialists, and demonstrations and which, in connection therewith, provides specialized, high-quality diagnostic and treatment services for inpatients and outpatients.

(d) the term “hospital” means a hospital as defined in section 625(c) or other health facility in which local capability for diagnosis and treatment is supported and augmented by the program established under this title.

(e) the term “nonprofit” as applied to any institution or agency means an institution or agency which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

(f) the term “construction” [includes] *means new construction of facilities for demonstrations, research, and training when necessary to carry out regional medical programs, alteration, major repair (to the extent permitted by regulations), remodeling and renovation of existing buildings (including initial equipment thereof), and replacement of obsolete, built-in (as determined in accordance with regulations) equipment of existing buildings.*

GRANTS FOR PLANNING

SEC. 903. (a) The [Surgeon General] *Secretary*, upon the recommendation of the National Advisory Council on Regional Medical Programs established by section 905 (hereafter in this title referred to as the “Council”), is authorized to make grants to public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private agencies and institutions, and combinations thereof, to assist them in planning the development of regional medical programs.

(b) Grants under this section may be made only upon application therefor approved by the **[Surgeon General] Secretary**. Any such application may be approved only if it contains or is supported by—

(1) reasonable assurances that Federal funds paid pursuant to any such grant will be used only for the purposes for which paid and in accordance with the applicable provisions of this title and the regulations thereunder;

(2) reasonable assurances that the applicant will provide for such fiscal control and fund accounting procedures as are required by the **[Surgeon General] Secretary** to assure proper disbursement of and accounting for such Federal funds;

(3) reasonable assurances that the applicant will make such reports, in such form and containing such information as the **[Surgeon General] Secretary** may from time to time reasonably require, and will keep such records and afford such access thereto as the **[Surgeon General] Secretary** may find necessary to assure the correctness and verification of such reports; and

(4) a satisfactory showing that the applicant has designated an advisory group, to advise the applicant (and the institutions and agencies participating in the resulting regional medical program) in formulating and carrying out the plan for the establishment and operation of such regional medical program, which advisory group includes practicing physicians, medical center officials, hospital administrators, representatives from appropriate medical societies, **[voluntary health agencies. and] voluntary health agencies, official health and planning agencies, and** representatives of other organizations, institutions, and agencies concerned with activities of the kind to be carried on under the program (*including as an ex officio member, if there is located in such region one or more hospitals or other health facilities of the Veterans' Administration, the individual whom the Administrator of Veterans' Affairs shall have designated to serve on such advisory group as the representative of the hospitals or other health care facilities of such Administration which are located in such region*) and members of the public familiar with the **[need for the services provided under the program] need for and financing of the services provided under the program, and which advisory group shall be sufficient in number to insure adequate community representation (as determined by the Secretary).**

GRANTS FOR ESTABLISHMENT AND OPERATION OF REGIONAL MEDICAL PROGRAMS

SEC. 904. (a) The **[Surgeon General] Secretary**, upon the recommendation of the Council, is authorized to make grants to public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private agencies and institutions, and combinations thereof, to assist in establishment and operation of regional medical programs, including construction and equipment of facilities in connection therewith.

(b) Grants under this section may be made only upon application therefor approved by the **[Surgeon General] Secretary**. Any such application may be approved only if it is recommended by the advisory group described in section **[903(b)(4) and] section 903(b)(4), if oppor-**

tunity has been provided, prior to such recommendation, for consideration of the application by each public or nonprofit private agency or organization which has the responsibility for development, a comprehensive regional, metropolitan area, or other local area plan referred to in section 314(b) covering any area in which the regional medical program for which the application is made will be located, and if the application contains or is supported by reasonable assurances that—

(1) Federal funds paid pursuant to any such grant (A) will be used only for the purposes for which paid and in accordance with the applicable provisions of this title and the regulations thereunder, and (B) will not supplant funds that are otherwise available for establishment or operation of the regional medical program with respect to which the grant is made;

(2) the applicant will provide for such fiscal control and fund accounting procedures as are required by the **【Surgeon General】 Secretary** to assure proper disbursement of and accounting for such Federal funds;

(3) the applicant will make such reports, in such form and containing such information as the **【Surgeon General】 Secretary** may from time to time reasonably require, and will keep such records and afford such access thereto as the **【Surgeon General】 Secretary** may find necessary to assure the correctness and verification of such reports; and

(4) any laborer or mechanic employed by any contractor or subcontractor in the performance of work on any construction aided by payments pursuant to any grant under this section will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—276a-5); and the Secretary of Labor shall have, with respect to the labor standards specified in this paragraph, the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z-15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

SEC. 905. (a) **【The Surgeon General, with the approval of the Secretary】** *The Secretary* may appoint, without regard to the civil service laws, a National Advisory Council on Regional Medical Programs. The Council shall consist of **【the Surgeon General】**, *the Assistant Secretary of Health, Education, and Welfare for Health and Scientific Affairs*, who shall be the chairman, *the Chief Medical Director of the Veterans' Administration who shall be an ex officio member*, and sixteen members, not otherwise in the regular full-time employ of the United States, who are leaders in the fields of the fundamental sciences, the medical sciences, *health care administration*, or public affairs. At least two of the appointed members shall be practicing physicians, one shall be outstanding in the study, diagnosis, or treatment of heart disease, one shall be outstanding in the **【study, diagnosis, or treatment of cancer】** *study of or health care for persons suffering from cancer*, **【and one shall be outstanding in the study, diagnosis, or treatment of stroke】** *one shall be outstanding in the study of or*

health care for persons suffering from stroke, one shall be outstanding in the study of or care for persons suffering from kidney disease, and three shall be members of the public.

(b) Each appointed member of the Council shall hold office for a term of four years, except that any member appointed to fill a vacancy prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the **[Surgeon General]** *Secretary* at the time of appointment, four at the end of the first year, four at the end of the second year, four at the end of the third year, and four at the end of the fourth year after the date of appointment. An appointed member shall not be eligible to serve continuously for more than two terms.

(c) Appointed members of the Council, while attending meetings or conferences thereof or otherwise serving on business of the Council, shall be entitled to receive compensation at rates fixed by the *Secretary*, but not exceeding \$100 per day, including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b-2) for persons in the Government service employed intermittently.

(d) The Council shall advise and assist the **[Surgeon General]** *Secretary* in the preparation of regulations for, and as to policy matters arising with respect to, the administration of this title. The Council shall consider all applications for grants under this title and shall make recommendations to the **[Surgeon General]** *Secretary* with respect to approval of applications for and the amounts of grants under this title.

REGULATIONS

SEC. 906. The **[Surgeon General]** *Secretary*, after consultation with the Council shall prescribe general regulations covering the terms and conditions for approving applications for grants under this title and the coordination of programs assisted under this title with programs for training, research, and demonstrations relating to the same diseases assisted or authorized under titles of this Act or other Acts of Congress.

INFORMATION ON SPECIAL TREATMENT AND TRAINING CENTERS

SEC. 907. The **[Surgeon General]** *Secretary* shall establish, and maintain on a current basis, a list or lists of facilities in the United States equipped and staffed to provide the most advanced methods and techniques in the diagnosis and treatment of heart disease, cancer, **[or stroke]** *stroke or kidney disease*, together with such related information, including the availability of advanced specialty training in such facilities, as he deems useful, and shall make such list or lists and related information readily available to licensed practitioners and other persons requiring such information. To the end of making such list or lists and other information most useful, the **[Surgeon General]** *Secretary* shall from time to time consult with interested national professional organizations.

REPORT

SEC. 908. On or before June 30, 1967, the Surgeon General, after consultation with the Council, shall submit to the Secretary for transmission to the President and then to the Congress, a report of the activities under this title together with (1) a statement of the relationship between Federal financing and financing from other sources of the activities undertaken pursuant to this title, (2) an appraisal of the activities assisted under this title in the light of their effectiveness in carrying out the purposes of this title, and (3) recommendations with respect to extension or modification of this title in the light thereof.

RECORDS AND AUDIT

SEC. 909. (a) Each recipient of a grant or contract under this title shall keep such records as the [Surgeon General] Secretary may prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grant or contract, the total cost of the project or undertaking in connection with which such grant or contract is made or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such records as will facilitate an effective audit.

(b) The Secretary of Health, Education, and Welfare and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipient of any grant under this title which are pertinent to any such grant.

**[PROJECT GRANTS FOR MULTIPROGRAM SERVICES]
MULTIPROGRAM SERVICES**

[SEC. 910. Funds appropriated under this title shall also be available for grants to any public or nonprofit private agency or institution for services needed by, or which will be of substantial use to, any two or more regional medical programs.]

SEC. 910. (a) *To facilitate interregional cooperation, and develop improved national capability for delivery of health services, the Secretary is authorized to utilize funds appropriated under this title to make grants to public or nonprofit private agencies or institutions or combinations thereof and to contract for—*

(1) *programs, services, and activities of substantial use to two or more regional medical programs;*

(2) *development, trial, or demonstration of methods for control of heart disease, cancer, stroke, kidney disease, or other major diseases or conditions;*

(3) *the collection and study of epidemiologic data related to any of the diseases and conditions referred to in paragraph (2);*

(4) *development of training specifically related to the prevention, diagnosis, or treatment of any of the diseases or conditions referred to in paragraph (2), or to the rehabilitation of persons suffering from any of such diseases or conditions; and for continuing programs of such training where shortage of trained personnel would otherwise limit application of knowledge and skills important to the control of any such diseases or conditions; and*

(5) *the conduct of cooperative clinical field trials.*

(b) *The Secretary is authorized to assist in meeting the costs of special projects for improving, or developing new means for, the delivery of health services concerned with any of the diseases or conditions with which this title is concerned.*

(c) *The Secretary is authorized to support research, studies, investigations, training, and demonstrations designed more effectively to utilize health personnel in the delivery of health services.*

